

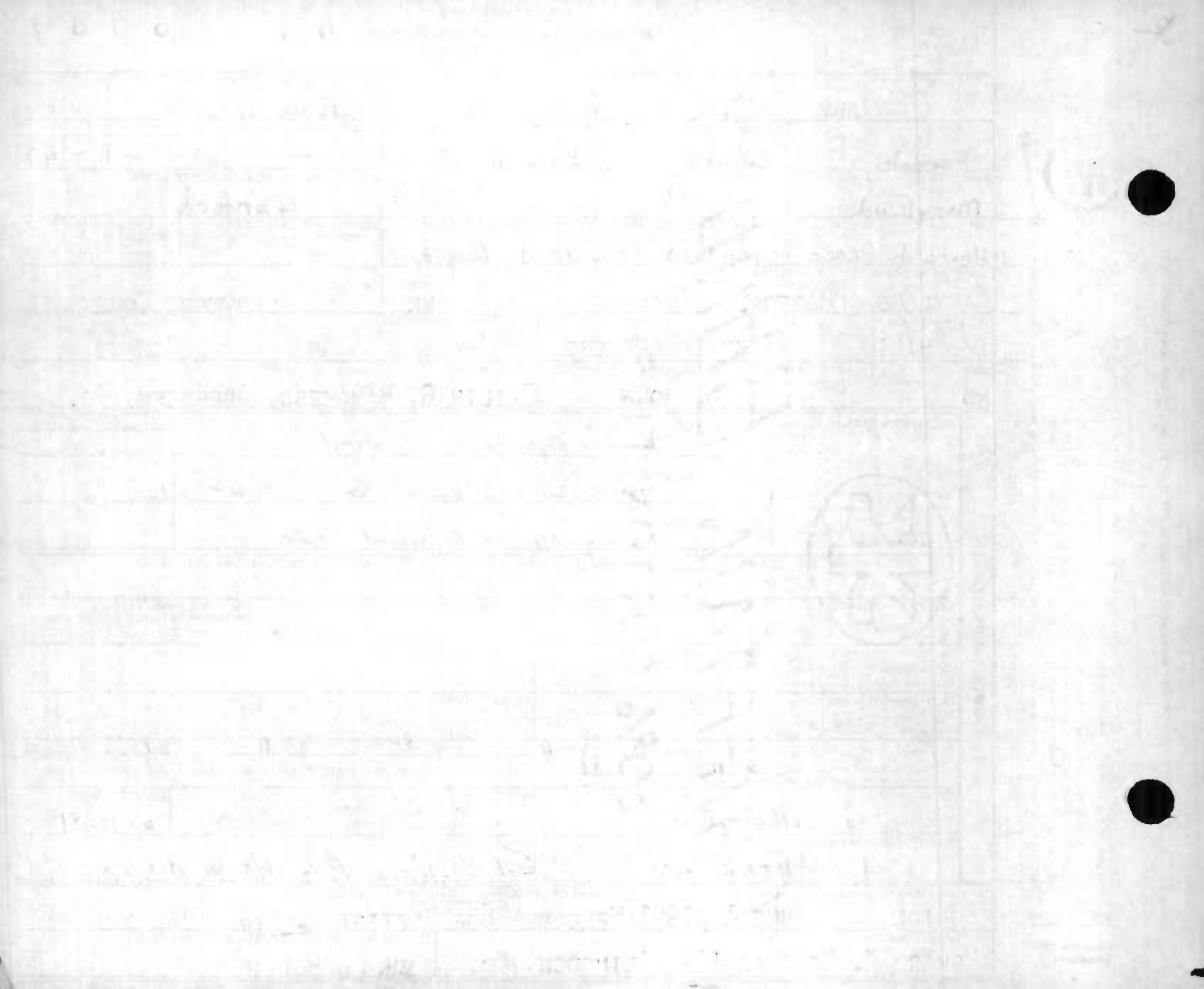
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8116089 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) BABY GIRL Bauguess | | | | 2a. DATE OF DEATH MONTH DAY YEAR June 11, 1981 | | | |
| 3. SEX Female | | | | 2b. HOUR 10 P M | | | |
| 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 11, 1981 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS — — — | | IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN — 49 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | |
| 10. CITY OR TOWN OF DEATH Havre de Grace | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) — | | 12b. KIND OF BUSINESS OR INDUSTRY — | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STREET ADDRESS | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY HARFORD | | 13c. CITY OR TOWN ABERDEEN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST PHILIP GARY BAUGUESS | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JEAN ANN SCHAUB | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ADDRESS PHILIP G. BAUGUESS, ABERDEEN, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest 7651 DUE TO, OR AS A CONSEQUENCE OF (b) Immaturity and low birth weight DUE TO, OR AS A CONSEQUENCE OF (c) 22 weeks gestational age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-11 19 81 , to 6-11 19 81 , that (I) (we) last saw the deceased alive on 6-11 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE A. Wheeler MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 6-11-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. WHEELER MD | | | | 22e. ADDRESS 501 So. Union Ave Havre de Grace Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JUNE 13, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY WELCOME HOME BAPTIST BELAIR CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE HARFORD MD. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS HOWARD K. McCOMAS III, ABINGDON, MD. | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 16 1981 Anthony McCready | | | |

BP



TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|--|---|---|-----------------|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | 2b. HOUR | | |
| Anna S. Beigel | | | | | | 6-16-81 | | | 11:40 P | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Female | | Cauc White | | 2 10 1898 | | 83 | | | MONTHS DAYS | | HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | MD. | | |
| Md. | | U.S.A. | | | | Harford Co. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| FALLSTON | | 2107 Buell Drive | | | | | | Housekeeper | | At Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2107 Buell Drive | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | | | | | | | | | FIRST MIDDLE LAST | | | |
| Joseph M C G Regan | | | | | | | | | | CARRIE | | Schriver | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| No | | 215-48-75647 | | Mrs James Ray Duerling | | Same | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 1749 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic carcinoma of Breast</u> | | | | | | | | | | 3 years | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1978</u> to <u>July 16 81</u> , that (I) (we) last saw the deceased alive on <u>March 81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | | | | | | | |
| Willard R Amoss | | | MD | | | 6/16/81 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | | |
| Willard R Amoss | | | 2404 Pleasantville Rd, Fallston, Md | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | 6-19-81 | | BALTO. NATIONAL | | BALTO | | | | Md | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| EVANS Funeral Chapel 8800 Harford Rd, Fallston, Md | | | | JUN 26 1981 | | | | Anthony McCreary | | | | | |



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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|---|--|--|--|--|---|--|--|-----------------------------------|
| 1. FOR STATE REGISTRAR | | | | | 8 1 1 6 0 9 1 | | | | | |
| CERTIFICATE OF DEATH | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Otis BERNARD Benjamin | | | | | 2a. DATE OF DEATH MONTH DAY YEAR June 6, 1981 | | | | | 2b. HOUR 1:42 M |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 11, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS. HOURS MIN. |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 10. CITIZEN OF WHAT COUNTRY? USA | | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | | | | |
| 10. CITY OR TOWN OF DEATH HAURE de GRACE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address) HARFORD Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheetmetal | | 12b. KIND OF BUSINESS OR INDUSTRY Bui lding | | | | |
| 13a. STATE MD | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN North East | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 549 BARON Rd. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Victor Benjamin | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alva Goodnow | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. 220-18-3806 | | 17. INFORMANT ADDRESS Paula B Penn CONOWINGO, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adult Respiratory distress syndrome DUE TO, OR AS A CONSEQUENCE OF (b) Fulminating pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Malignant Arrhythmia | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-31 , 19 81 , to 6-6 , 19 81 , that (I) (we) last saw the deceased alive on 6-6 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Brian T. You M.D. | | | | | | 22c. DATE SIGNED 6/6/81 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brian T You M.D. | | |
| 22e. ADDRESS HAURE de GRACE, MD | | | | | | 22f. NAME OF CEMETERY OR CREMATORY Bayview | | | | |
| 22g. DATE 6-9-81 | | | | | | 22h. LOCATION CITY OR TOWN COUNTY STATE North East Cecil MD | | | | |
| 22i. NAME OF CEMETERY OR CREMATORY Bayview | | | | | | 22j. DATE REC'D. BY REGISTRAR JUN 10 1981 | | | | |
| 22k. REGISTRAR'S SIGNATURE Paul R. Crouch | | | | | | 22l. REGISTRAR'S SIGNATURE Paul R. Crouch | | | | |

Dear Mr. [Name]
[Faint, mostly illegible text in the first section of the letter, possibly mentioning a meeting or appointment.]

[Faint, mostly illegible text in the second section of the letter, possibly concluding the correspondence.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 0 9 2

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) MARILEA POWELL Bennington | | | 2a. DATE OF DEATH MONTH DAY YEAR June 13, 1981 | | 2b. HOUR 2:40 AM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR JUNE 27, 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS 54 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | |
| 10. CITY OR TOWN OF DEATH HAVRE DE GRACE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SCHOOL TEACHER | |
| 13a. STATE MD. | | 13b. COUNTY HARFORD | 13c. CITY OR TOWN HAVRE DE GRACE | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 100 N Lapidum Rd. |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILBUR LEE POWELL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ORABELLA - REDDISH | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215-20-1525 | | 17. INFORMANT ADDRESS JESSIE T. BENNINGTON - SAME | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced carcinoma. 1579 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of pancreas. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-3 , 19 81 , to 6-13 , 19 81 , that (I) (we) lost saw the deceased alive on 6-13 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE | | 22c. DATE SIGNED June 13 '81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) I. D. SOMARVILLE | | 22e. ADDRESS 400 LEWIS ST HAVRE DE GRACE Md. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JUNE 15, '81 | | 23c. NAME OF CEMETERY OR CREMATORY HARFORD MEM GARDENS - HARFORD MD | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE HARFORD MD | | 24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME, HAVRE DE GRACE MD | | | |
| DATE REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE JUN 16 1981 | | | |

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BP



FRANK

MD

MD

HARTFORD

WILSON LEE POWELL - CHASELLA - FARRIS

WILSON LEE POWELL - CHASELLA - FARRIS

WILSON LEE POWELL - CHASELLA - FARRIS

WILSON LEE POWELL - CHASELLA - FARRIS

WILSON LEE POWELL - CHASELLA - FARRIS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 0 9 3

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE H. BISHOP | | | 2a. DATE OF DEATH MONTH DAY YEAR 6 3 81 | | | 2b. HOUR 6:15 A.M. | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 4 11 94 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | |
| 10. CITY OR TOWN OF DEATH FALLSTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Baldwin | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel Smith Bishop | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Alice Bishop | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 221016097 | | 17. INFORMANT ADDRESS Carolyn B. Hise - As Above | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced Carcinoma of Colon</u> Cystic Heart Failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|--|--|

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | |
| <u>(b) Pneumonia, Renal Insufficiency</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | |

| | | | | | |
|--|--|--|--|---|--|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

| | | | | | |
|--|--|---|--|-----------------------------------|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/27</u> 19 <u>81</u> to <u>6/3</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>6/3</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>MM Lopez</u> | | DEGREE MD | | 22c. DATE SIGNED <u>6/3/81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAZARUS MANUEL | | 22e. ADDRESS 1131 Bel Air Rd. Bel Air Maryland 21014 | | | |

| | | | | | | | |
|---|--|---------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 6/5/81 | | 23c. NAME OF CEMETERY OR CREMATORY Gracelawn M. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE New Castle " " Delaware | |
| 24. FUNERAL DIRECTOR NAME <u>Bonnie Dickerson</u> | | ADDRESS 412 Phila Pk Wilm DE | | 25a. DATE REC'D. BY REGISTRAR JUN 9 1981 | | 25b. REGISTRAR'S SIGNATURE <u>Carolyn Hise</u> | |

1997-1998

107-167

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 1 6 0 9 4 | | | |
|---|--|--|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | 2a DATE OF DEATH | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | |
| Norval Taylor Bodt | | | | June 10 81 | | | |
| 3 SEX Male | | | | 7:30 a.m. | | | |
| 4 RACE White | | | | 2b HOUR | | | |
| 5 DATE OF BIRTH | | | | 6 AGE (IN YEARS (LAST BIRTHDAY)) | | | |
| MONTH DAY YEAR | | | | YRS MONTHS DAYS | | | |
| 9 20 17 | | | | 63 | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| Maryland | | | | USA | | | |
| 7b CITIZEN OF WHAT COUNTRY? | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| USA | | | | Harford MD | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | |
| Bel Air | | | | Bel Air Convalescent Center, Inc. | | | |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Purchasing Agent | | | | Federal | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d INSIDE CITY LIMITS? | | | |
| 13a STATE 13b CITY 13c CITY OR TOWN | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| Maryland Harford Churchville | | | | 13e STREET ADDRESS | | | |
| | | | | 2921 Churchville Road | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| WILLIAM ARCHER Bodt | | | | MAYME JEANETTE MAGNESS | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b SOCIAL SECURITY NO. | | | |
| Yes | | | | 217-05-4508 | | | |
| 17 INFORMANT ADDRESS | | | | 17b | | | |
| Emylon Bodt, 2921 Churchville Rd, | | | | Churchville, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | 36 hrs | | | |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u> | | | | | | | |
| 1629 | | | | 2 yrs | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | 6 mos. | | | |
| b) <u>CARCINOMA of Lung + Larynx and</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| c) <u>METASTASIS to BRAIN</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| None | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | |
| | | | | P.M. 19 | | | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 6-1-81, 1981, to 6-10, 1981, that (I) (we) lost saw the deceased alive on 6/9, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | | | | 22c. DATE SIGNED | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | |
| Dudley Phillips | | | | 6/10/81 | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22c. DATE SIGNED | | | |
| Dudley Phillips, M.D. | | | | 6/10/81 | | | |
| 22b. ADDRESS | | | | 22c. DATE SIGNED | | | |
| Masonic Building, Darlington, Md. 21034 | | | | 6/10/81 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | |
| BURIAL | | | | JUNE 12, 1981 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| SMITH'S CHAPEL | | | | CHURCHVILLE-HARFORD-MD. | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | |
| HOWARD K. McCOMAS III, ABINGDON, Md. | | | | JUN 11 1981 | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 0 9 5

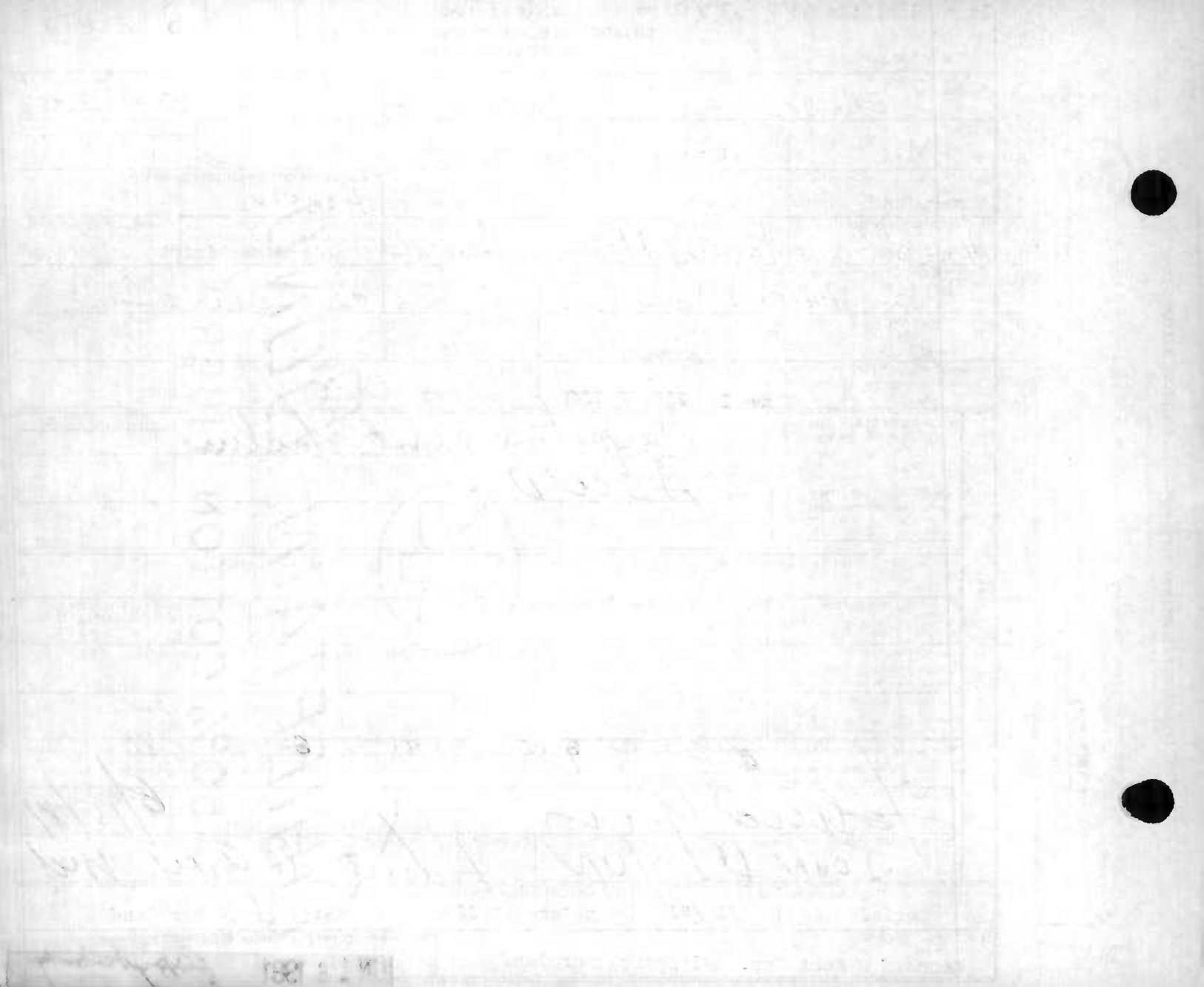
| FOR 1. STATE REGISTRAR | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward L BREWER JR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 6-15-81 2b. HOUR P 2:35 M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 13, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | |
| 10. CITY OR TOWN OF DEATH HAURE DE GRACE HARFORD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY HARFORD | | 13c. CITY OR TOWN Edgewood | | 13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward L Brewer Sr | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada ? ? | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II I | | | |
| 17. SOCIAL SECURITY NO. 215-07-3340 | | 18. INFORMANT Mrs Betty R Falls | | | | 19. ADDRESS Same | |
| 20. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) ASACD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 21a. DATE OF OPERATION | | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 24a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 24b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 24c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 25. I certify that (I) (this hospital) attended the deceased from 6-15 19 81 to 6-15 19 81 that (I) (we) last saw the deceased alive on 6-15 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 26a. SIGNATURE John D. Yun | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | DATE SIGNED 6/15/81 | |
| 27a. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Yun | | 27b. ADDRESS Haure de Grace, Md | | | | | |
| 28a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 28b. DATE 6/18/81 | | 28c. NAME OF CEMETERY OR CREMATORY Dulaney Valley | | 28d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 29. FUNERAL DIRECTOR NAME ADDRESS Leonard J Ruck Inc. Baltimore, Maryland | | | | 30a. DATE REC'D. BY REGISTRAR JUN 16 1981 | | 30b. REGISTRAR'S SIGNATURE Esther Halmon | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 0 9 6

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Marjorie VIERS Brint | | | 2a. DATE OF DEATH MONTH DAY YEAR 6 12 81 | | | 2b. HOUR 2:55 P.M. | | | |
| 3. SEX F | | 4. RACE Cauc | | 5. DATE OF BIRTH MONTH DAY YEAR 4 17 29 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENN. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH FALLSTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY -- | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Md | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Fallston | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1506 Ryan Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EVERETT -- VIERS | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OLIVE RUTH WOODS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO. 410-46-8999 | | 17. INFORMANT MICHAEL L. BRINT, 3 SIGWIN DR., WALLINGFORD, CONN. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Endometrial Carcinoma 1820 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6 4 81 P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 61 4/81 | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 612 81 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/12/81 19 81 , to 6/12 19 81 , that (I) (we) last saw the deceased alive on 6/12/81 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Willard P. Amos | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 6/12/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Willard P. Amos | | | 22e. ADDRESS 2404 Pleasantville Rd, Fallston Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL | | | 23b. DATE JUNE 12, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY FUNERAL HOME GEO. A. SMITH & SON | | 23d. LOCATION CITY OR TOWN COUNTY STATE JACKSON-MADISON-TENN. | | |
| 24. FUNERAL DIRECTOR NAME HOWARD K. McCOMAS III, ABINGDON, MD. | | | ADDRESS | | | 25. DATE REC'D. BY REGISTRAR JUN 15 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

0 1 2 3 4 5 6 7 8 9 10 11 12

13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300

301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400

401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500

501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600

601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700

701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800

801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900

901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 16097 | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 26. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Francis Howard Britcher | | | | | | | | | | 26. DATE KNOWN OF DEATH ESTIMATED 6 6 19 81 | |
| 3. SEX M 4. RACE W 5. DATE OF BIRTH MONTH DAY YEAR MAY 15 1917 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | | | | | | | | | 26. DATE KNOWN OF DEATH ESTIMATED 6 6 19 81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED XX NEVER MARRIED WIDOWED DIVORCED | | | | | | | | | | 26. DATE KNOWN OF DEATH ESTIMATED 6 6 19 81 | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | | | | | | | | | | 26. DATE KNOWN OF DEATH ESTIMATED 6 6 19 81 | |
| 10. CITY OR TOWN OF DEATH EDGEWOOD 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2423 SYCAMORE LANE 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT 12b. KIND OF BUSINESS OR INDUSTRY CANCER SOC. | | | | | | | | | | 26. DATE KNOWN OF DEATH ESTIMATED 6 6 19 81 | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND 13c. CITY OR TOWN HARFORD 13d. INSIDE CITY LIMITS? YES NO 13e. STREET ADDRESS 2423 SYCAMORE LANE | | | | | | | | | | 26. DATE KNOWN OF DEATH ESTIMATED 6 6 19 81 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN HOWARD BRITCHER 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH -- NEWCOMB | | | | | | | | | | 26. DATE KNOWN OF DEATH ESTIMATED 6 6 19 81 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 215-10-6186 17. INFORMANT ADDRESS MRS. ANNA B. BRITCHER, EDGEWOOD, MD. | | | | | | | | | | 26. DATE KNOWN OF DEATH ESTIMATED 6 6 19 81 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 CORONARY HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES NO | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner | | | | | | | | | | | |
| ACTUAL SIGNATURE L. E. Rempel M.D. DEPUTY MEDICAL EXAMINER TITLE (SPECIFY) DATE SIGNED 6-6-81 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) L. E. Rempel ADDRESS 464 Alliance St Harford Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE JUNE 9, 1981 23c. NAME OF CEMETERY OR CREMATORY BEL AIR MEM. GARDENS 23d. LOCATION CITY OR TOWN COUNTY STATE BEL AIR HARFORD MD. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME HOWARD K. MCCOMAS III, ABINGDON, MD. 25a. DATE REC'D. BY REGISTRAR JUN 8 - 1981 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

22

THE COLLEGE OF THE CITY OF NEW YORK

1890

1890

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---------------------|--|---|--|--------------------------------|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY T. BUCKELEW | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 6-9 19 81 | | | 2b. HOUR AM PM 8 AM | | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 10/6/20 60 YRS. | 6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. 60 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6-9 19 81 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County | | | 10. CITY OR TOWN OF DEATH Fallston | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | 13a. STREET ADDRESS 3750 Jarrettsville Pike | | |
| 13a. STATE Maryland | | | 13b. CITY OR TOWN Baltimore | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry Hammond Thomas | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy I. Richards | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | |
| 16b. SOCIAL SECURITY NO. 214 14 7447 | | | 17. INFORMANT Thomas A. Bucklew, Towson, Md. | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Hypertension | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Samuel H. Henck | | | TITLE (SPECIFY) Deputy | | | DATE SIGNED 6/9/81 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Samuel H. Henck | | | ADDRESS 721 White Ford, Md. 21160 | | | 23b. REGISTRAR'S SIGNATURE Esther H. Henry | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 6/12/81 | | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Maryland | | | 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. | | | 25a. DATE REC'D. BY REGISTRAR JUN 10 1981 | | |
| 4905 York Road Balto., Md. 21212 | | | 25b. REGISTRAR'S SIGNATURE Esther H. Henry | | | | | |

West York Road, Md., 21212

Henry W. Jones & Sons Co.,
Drugs, Bridgetown, Barbados

Princeton, Maryland

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

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Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 1 1 6 0 9 9 | | | |
|---|--|---|--|---|---|--|--|--|---|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) GRACE Marie BULL | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 6 1 81 | | | | 2b. HOUR 2:40 M | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 8-26-8917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Havre de Grace | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland | | | | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Abingdon | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Arthur O Ashley | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie Williams | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. 217-20-8054 | | 17. INFORMANT ADDRESS Peyton Niswonger 919 S. Stepney Rd. Aberdeen | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4292 Cardiac Decompensation IMMEDIATE CAUSE (a) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (b) — DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2-3 years. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cerebral Vascular thrombosis, Senility | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION — | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) — | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — — | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/1/81 to 6/1/81 , that (I) (we) last saw the deceased alive on 6/1/81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Edward C. Loo, M.D. | | | | | | | | DEGREE M.D. | | 22c. DATE SIGNED 6/1/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. LOO, M.D. | | | | | | | | 22e. ADDRESS Havre de Grace, Md. 21078 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 6-4-81 | | 23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home PA, Aberdeen, Maryland | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 5 1981 | | 25b. REGISTRAR'S SIGNATURE Robert M. ... | | | |

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Hel Air New, Garbo, Tel Air Harford Maryland

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Rayton Missionary, 219 S. Stearns St., Alameda

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9. *Journal of the American Medical Association*, 1990; 263: 1025-1028.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 16100 | | | |
|--|--|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| HERMINE Thalia CARBARY | | | | June 20 81 | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | White | | 8 2 1892 | | 88 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| New York | | USA | | | | Harford MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| HAUTE DE GRACE | | Harford Memorial Hosp | | Sample Dress Maker | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | |
| Md | | | | Harford | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| Richard Schwabe | | | | Hermine Kallmeyer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | | | 145-10-0425 | | Belair, Md. Mrs. Gloria Hastings, 615 Fox Bow Dr. 21014 | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute & chronic pul. edema</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-7 19 81, to 6-20 19 81, that (I) (we) last saw the deceased alive on 6-20 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| John D. Yun | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 6/20/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| John D. Yun | | | | Haute de Grace, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 6-23-1981 | | Fairview Cem. | | Md. State of Monmouth, N. Jersey | |
| 24. FUNERAL DIRECTOR | | | | 25. REGISTRAR'S SIGNATURE | | | |
| E.F. Tassahn, 11750 Belair Rd. Kingsville, Md. 21087 | | | | JUN 24 1981 | | | |

Accepted for deposit
March 10, 1900

James D. Smith
March 10, 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|---|---|--|---|--|-----------------------------------|---|--|
| 1- FOR STATE REGISTRAR | | | | | 8 1 1 6 1 0 1 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | |
| JOHN F Collins | | | | | MONTH DAY YEAR 06-13-81 | | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | | |
| M | | Black | | MONTH DAY YEAR 11 21 97 | | 83 YRS | | 10 48 AM | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| MD | | U.S.A. | | | | Harford MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Fallston | | Fallston General Hospital | | | | retired | | Construction | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MD | | | | | HARford | | Bel Air | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME | | | | | 15 MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST Samuel F Collins | | | | | FIRST MIDDLE LAST MARGARET Dutton | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | | | 218-05-6064 | | Addie B. Collins 2824 Forge Hill Road Bel Air, MD. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | | | |
| 4269 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) COMPLETE HEART BLOCK. | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| AT WORK | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost | | | | | | | | | | |
| saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | |
| above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | | |
| V. M. ABHYANKAR | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 13 JUNE 81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | |
| V. M. ABHYANKAR | | | | | FALLSTON GEN. HOSPITAL, FALLSTON, MD 21047 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | | 6-16-81 | | CLARKS Chapel | | CITY OR TOWN COUNTY STATE Bel Air Harford Md | | | |
| 24 FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | |
| NAME ADDRESS Arnold W. Beaton 117 E. Cecil Ave. N.E. MD | | | | | JUN 15 1981 | | | | | |

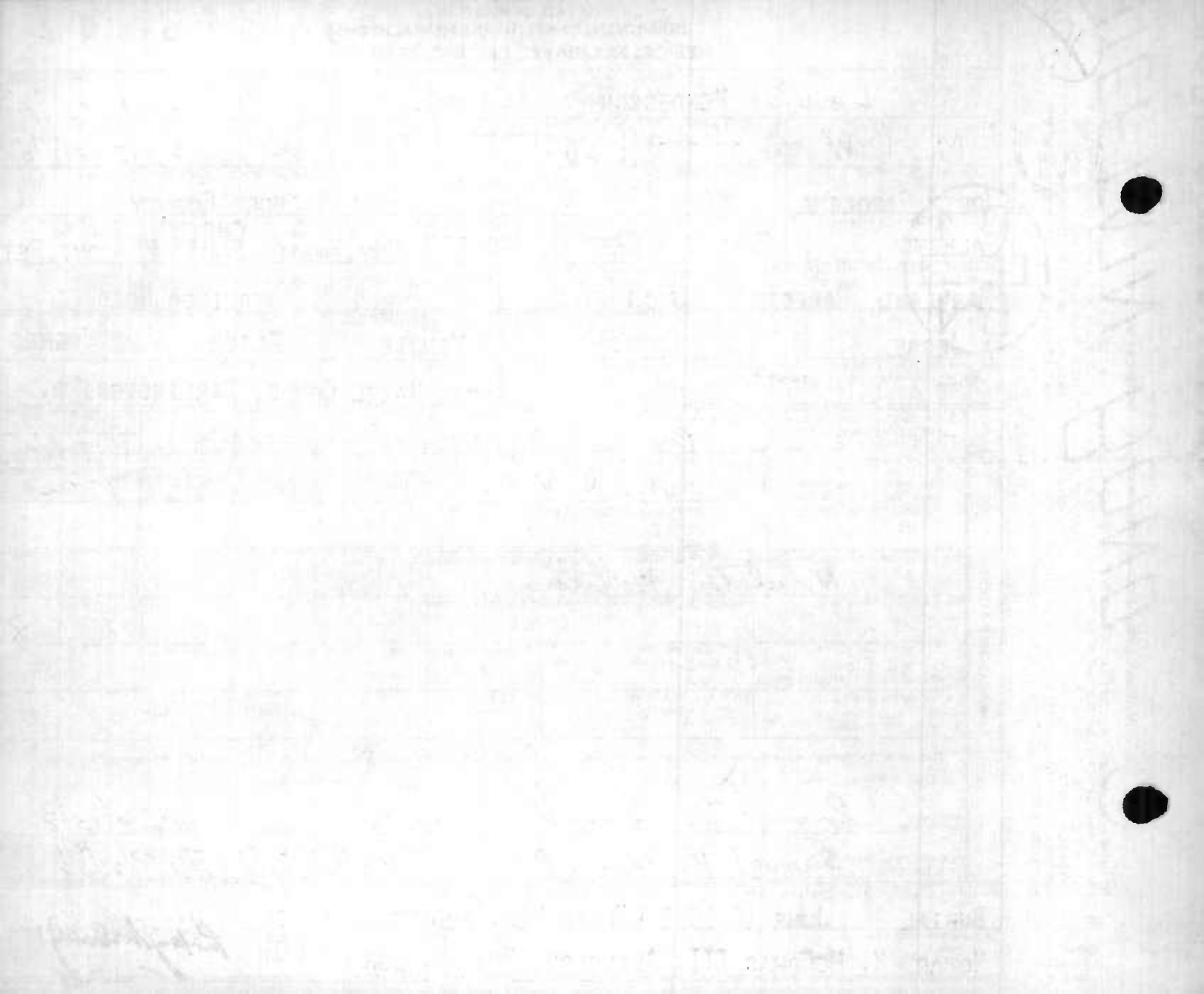
1845

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 16102 | | | | | |
|--|--|------------------|--|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Lewis HENDERSON Combs | | | | | | | | | | 7a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 6-13 1981 | | 7b. HOUR 7:10 P.M. | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH (MONTH DAY YEAR) MAR. 13, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 6-13 1981 | | 7d. HOUR 7:10 P.M. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY | | MD. | |
| 10. CITY OR TOWN OF DEATH FALLSTON | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION Hvy. MOBILE EQUIP. | | | | 12b. KIND OF BUSINESS OR INDUSTRY US-GOVT, RET | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | |
| 13a. STATE MARYLAND | | | | 13b. CITY OR TOWN HARFORD | | | | 13c. CITY OR TOWN DARLINGTON | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 4305 CONOWINGO ROAD | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) JESSE W. COMBS | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) VERDIE ALICE JOINES | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. 220-05-2658 | | | | 17. INFORMANT MRS. HAZEL COMBS, DARLINGTON, MD. | | | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Samuel H. Henck | | | | TITLE (SPECIFY) Deputy | | | | MEDICAL EXAMINER 721 Whiteford School Rd. Md. 21160 | | | | DATE SIGNED 6/13/81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Samuel H. Henck, M.D. | | | | ADDRESS | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE JUNE 16, 1981 | | | | 23c. NAME OF CEMETERY OR CREMATORY BELAIR MEM. GARDENS | | | | 23d. LOCATION (CITY OR TOWN) BEL AIR COUNTY HARFORD STATE MD. | | | |
| 24. FUNERAL DIRECTOR NAME HOWARD K. McCOMAS III | | | | ADDRESS ABINGDON, MD. | | | | 25a. DATE REC'D. BY REGISTRAR JUN 16 1981 | | | | 25b. RE | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 1 6 1 0 3 | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Col. BUCKNER Miller CREE L | | 2a. DATE OF DEATH 6-12-81 | | 2b. HOUR 10 ^{PM} | | | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH 3 25 96 | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | 8. IF UNDER 24 HRS HOURS MIN | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky | 9b. CITIZEN OF WHAT COUNTRY? U.S.A. | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | | | |
| 12. CITY OR TOWN OF DEATH FAHSTON | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Army-Retired | | 15. KIND OF BUSINESS OR INDUSTRY U.S. Govt. | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 18a. STATE Maryland | 18b. COUNTY Harford Co. | 18c. CITY OR TOWN Darlinton | 19. STREET ADDRESS Box #8 (Stafford Farm-Stafford Road) | | | | |
| 20. FATHER'S NAME FIRST MIDDLE LAST Buckner Miller CREE L | | 21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Thompson | | | | | |
| 22a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES-Army-Ret. | | 22b. SOCIAL SECURITY NO 1940-1946 226-24-4829 | | 23. INFORMANT (WIFE) 457-4251 ADDRESS Box #8 - (Stafford Rd) Mrs. Margaret C. Creel Darlington, Maryland 21034 | | | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular Fib. Cardiac Arrest.</u> 3369 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CHR. Resp. failure, Rheu. Arthrih's.</u> (c) <u>Critical Cord Compression, RLL atelectasis.</u> | | | | | | | 25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 26a. DATE OF OPERATION | | 26b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 27a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 27b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 28a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 28b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 28c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 29a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 29b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 29c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 30. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased die on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 31a. SIGNATURE | | 31b. DEGREE MD - ATTENDING PHYSICIAN | | 31c. MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 31d. DATE SIGNED 6-12-81 | |
| 32a. PHYSICIAN'S NAME (TYPE OR PRINT) B. PAREKH MD - | | 32b. ADDRESS 1131 Bel Air Rd. Bel Air MD 21014 | | | | | |
| 33a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 33b. DATE JUNE 15, 1981 | | 33c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cath. Ch. Cem, | | 33d. LOCATION CITY OR TOWN COUNTY STATE Forest Hill Harford Co., Maryland 21050 | |
| 34. FUNERAL DIRECTOR William Foster | | 34b. ADDRESS W. Broadway & Williams St Bel Air Md 21014 | | 35. DATE REC'D BY REGISTRAR JUN 16 1981 | | 35b. REGISTRAR'S SIGNATURE | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

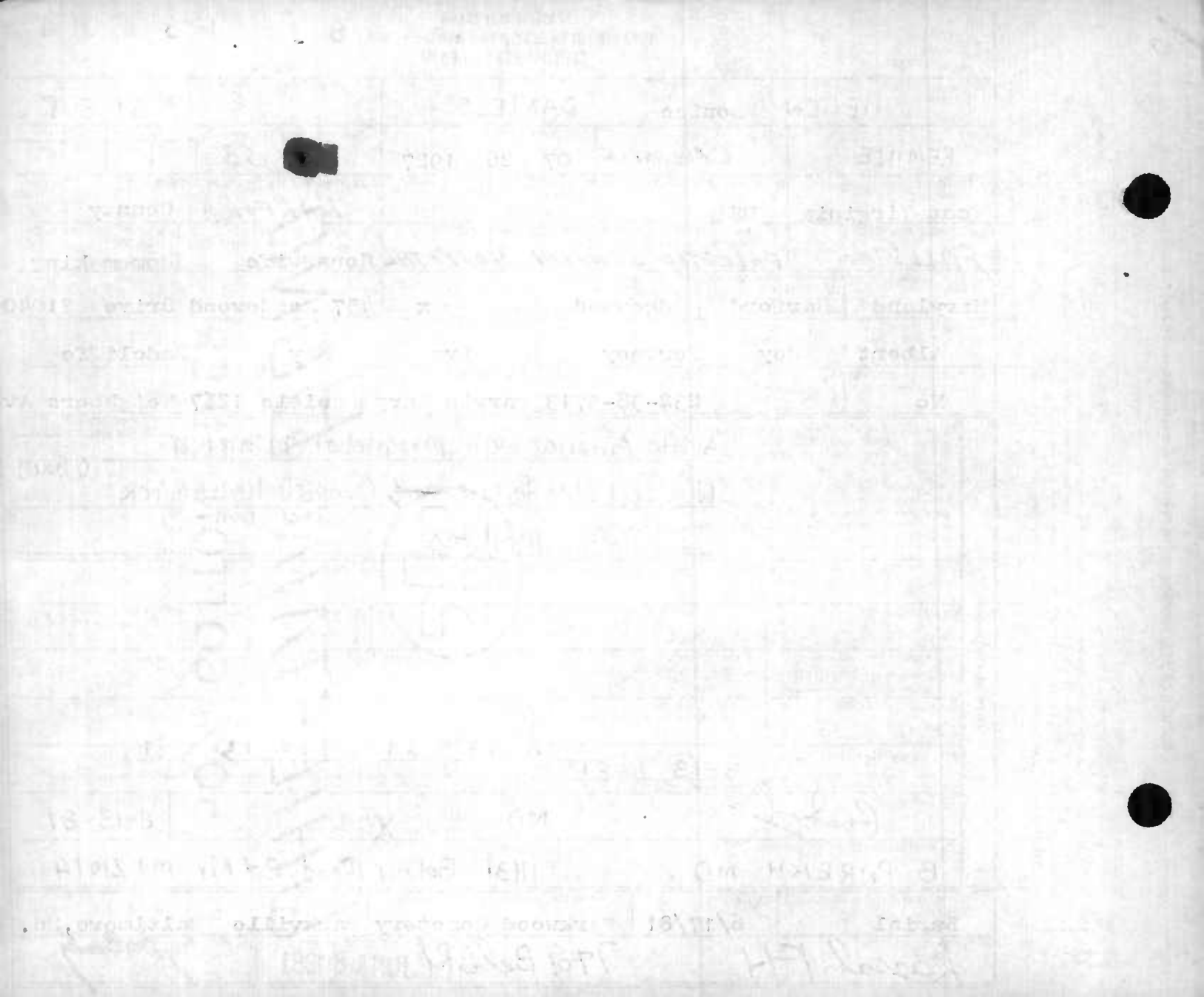
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 1 0 4

| | | | |
|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) HELEN Louise DANIELS | | 2a. DATE OF DEATH MONTH 6 DAY 13 YEAR 81 2b. HOUR 8 P M | |
| 3. SEX FEMALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH 07 DAY 26 YEAR 1927 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | 7b. CITIZEN OF WHAT COUNTRY? USA | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH FALLSTON | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD County MD. | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | |
| 13a. STATE Maryland | | 12b. KIND OF BUSINESS OR INDUSTRY Homemaking | |
| 13b. COUNTY Harford | 13c. CITY OR TOWN Edgewood | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Albert MIDDLE Roy LAST Fortney | | 15. MOTHER'S MAIDEN NAME FIRST Iva MIDDLE May LAST Radcliffe | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 232-38-5713 | |
| 17. INFORMANT Darwin Gary Daniels | | ADDRESS 1267 Neighbors Av | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Anterior wall myocardial infarction 2500 } DUE TO, OR AS A CONSEQUENCE OF (b) With Left vent failure and Complete Heart Block Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus. and any other | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hours | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-13-1981 to 6-13-1981 , that (I) (we) lost saw the deceased alive on 6-13-1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE B. PAREKH | | DEGREE MD | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) B. PAREKH MD. | | 22d. ADDRESS 1131 - Bel Air Road, Bel Air MD. 21014 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/17/81 | |
| 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION CITY OR TOWN Parkville COUNTY Baltimore STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Lassahn F/H | | 25. DATE REC'D. BY REGISTRAR JUN 18 1981 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 1 1 6 1 0 5 | | | |
|---|--|---|--|---|--|---|--|--|--|---|-----|---|----------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| Gaetano | | DiGiovanni | | | | | | 6 | | 6 | 81 | 10:28 ^P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Male | | White | | Aug 7, 1892 | | 88 | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Italy | | USA | | | | Harford MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Havre de Grace | | Citizens Nursing Home | | Self Employed | | Tavern Owner | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | | | |
| Maryland | | Cecil | | Charlestown | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Bladen Street | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | | LAST | | | |
| Unknown | | Unknown | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | |
| no | | 218-34-2081 | | Richard DiGiovanni, Port Deposit, Maryland | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Arterio-sclerotic CV disease</u> | | | | | | | | | | | | | |
| 4292 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (b) <u>Chronic brain syndrome</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | |
| J. Lee | | | | MD | | | | 6/8/81 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | |
| J. Lee | | | | Union Med. Clinic, Havre de | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | | June 10, 1981 | | Mt. Erin Cemetery | | Havre de Grace, Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25. DATE RECD. BY REGISTRAR | | | | 26. REGISTRAR'S SIGNATURE | | | | | |
| Lee A. Patterson & Son, Perryville, Maryland. | | | | JUN 19 1981 | | | | [Signature] | | | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8116106 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM EDGAR DOLAN | | | | 2a. DATE OF DEATH MONTH DAY YEAR 6-1-81 | | 2b. HOUR 6:05 PM | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 1 29 99 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | |
| 10. CITY OR TOWN OF DEATH FALLSTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Telephone Company | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford Co. 13c. CITY OR TOWN Bel Air | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 956-D Pentwood Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Henry DOLAN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie May Burkentine | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212-05-0704 | | 17. INFORMANT (WIFE) 838-6528 ADDRESS Mrs. Edna Dolan 956-D Pentwood Rd. Bel Air, Maryland 21014 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4409 CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CONGESTIVE HEART FAILURE, CA OF LUNG | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on 6/1/81, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Dante N. Monakile DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 6/1/81 | | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE N. MONAKILE | | | | 23b. ADDRESS Fallston Gun Hwy. Fallston, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE JUNE 4, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland | |
| 24. FUNERAL DIRECTOR Joseph William Foster W. Broadway & Williams Sts. Bel Air, Maryland 21014 | | | | 25a. DATE REGD. BY REGISTRAR JUN 5 1981 | | 25b. REGISTRAR'S SIGNATURE | |

NAME: [illegible]
ADDRESS: [illegible]
CITY: [illegible]

FRUIT & VEGETABLE MARKET
[illegible]

NO. [illegible]
[illegible]

ORDER FORM
[illegible]

DATE: [illegible]
[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

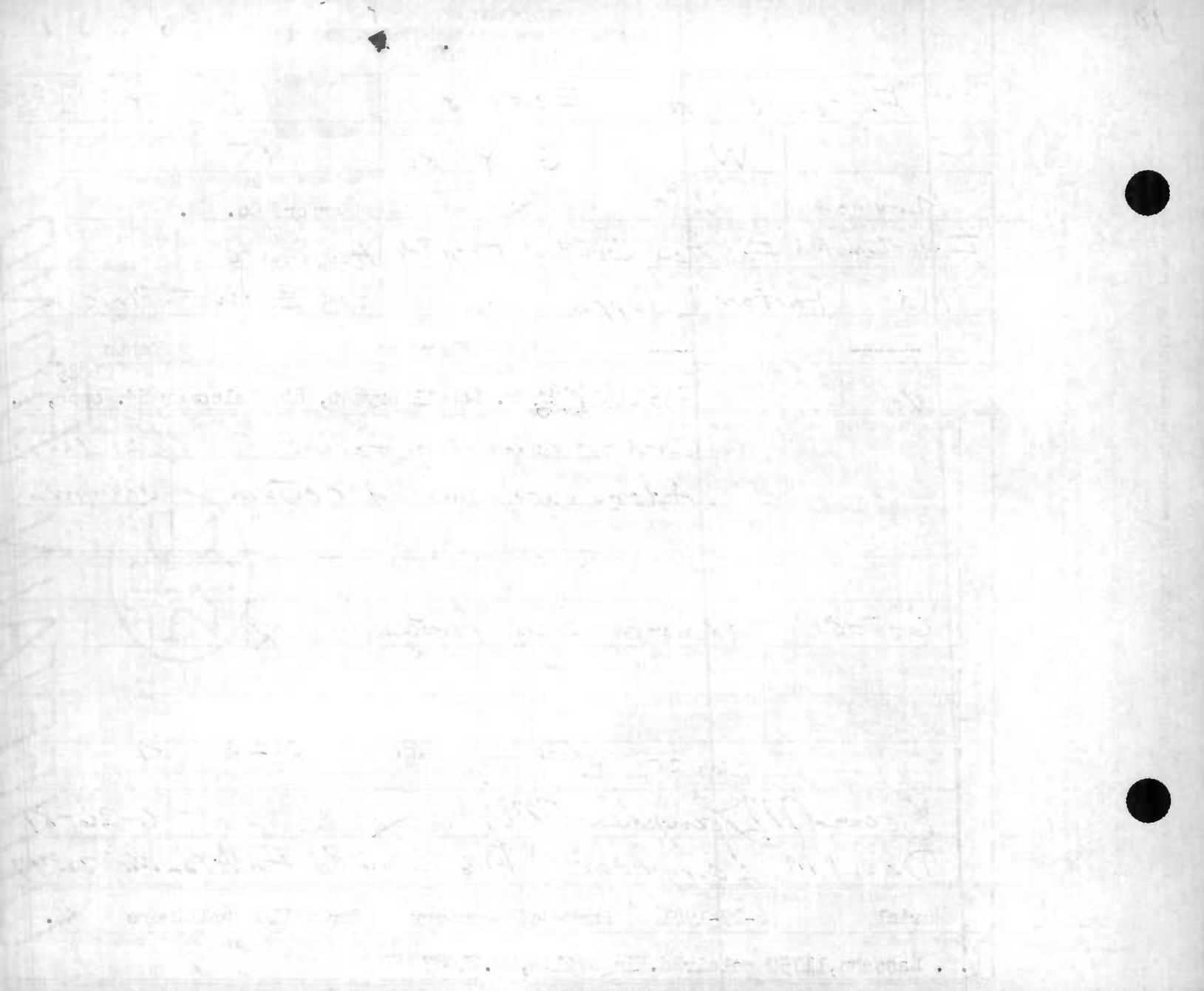
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

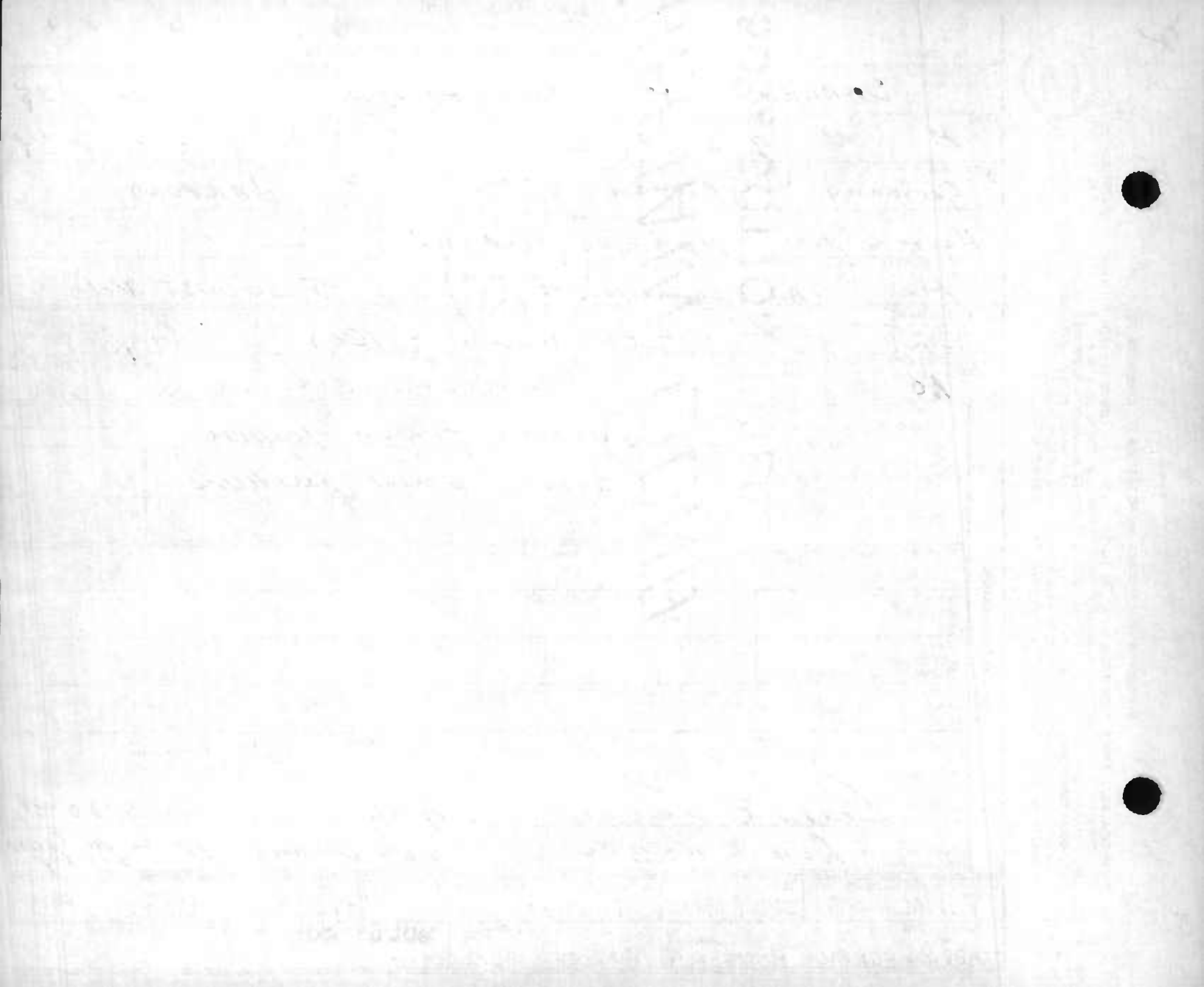
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|--|--|--|---|---|-------------------------|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | 6 8 1 1 6 1 0 7 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | REG. NO. | | | | | |
| FLORENCE A. ECKELS | | | | | 7a. DATE OF DEATH MONTH DAY YEAR 6-26-81 | | | | | |
| 2. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 6 8 86 | | 6. AGE (IN YEARS LAST BIRTHDAY) 9.5 YRS. | | 7b. HOUR 12 PM | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co., Md. MD. | | | | |
| 10. CITY OR TOWN OF DEATH Fallston Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md | | | | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Joppa | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Fehte | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-33-3899 | | 17. INFORMANT ADDRESS 21085 Mr. Lowell Bryant, 807 Falconer Rd. Joppa, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure 1541 DUE TO, OR AS A CONSEQUENCE OF (b) Adeno carcinoma of rectum DUE TO, OR AS A CONSEQUENCE OF (c) unknown APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 days | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | |
| 19a. DATE OF OPERATION 6-5-81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Adeno-carcinoma of rectum | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-1-81, 19 81, to 6-26-81, 19 81, that (I) (we) lost the deceased alive on 6-25-81, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE David M. Lanphear M.D. DEGREE | | | | | | 22c. DATE SIGNED 6-26-81 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) David M. Lanphear | | | | 22f. ADDRESS 1916 Belair Rd Fallston Md 21047 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6-29-1981 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR NAME E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087 | | | | 25a. DATE REC'D. BY REGISTRAR JUN 30 1981 | | 25b. REGISTRAR'S SIGNATURE | | | | |

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 16108 | |
|--|------------------|---|---|---|--|--|--|---|--|---|--|
| 1- STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) DARREN P FAZEKASH | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED 6 30 19 81 | | 2b. HOUR 3 30 PM | | | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH MONTH 9 DAY 6 YEAR 68 | 6. AGE (IN YEARS) LAST BIRTHDAY 12 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH 6 DAY 30 YEAR 19 81 | | 2d. HOUR 3 30 PM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany | | 7b. CITIZEN OF WHAT COUNTRY? German | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Harre de Spae | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY HARFORD | | 13c. CITY OR TOWN Aberdeen | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 520051 Rd. | | | |
| 14. FATHER'S NAME FIRST HORST MIDDLE LAST FAZEKASH | | | | 15. MOTHER'S MAIDEN NAME FIRST Eileen MIDDLE LAST GARVEY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. -N/A- | | 17. INFORMANT ADDRESS ABERDEEN, MD. 21001 HORST FAZEKASH #5 LOCUST RD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Chronic renal failure DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Rene E Renjel | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 6-30-81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) RENE E RENJEL | | | | ADDRESS 464 Alliance Rd H de Spae 21001 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE JULY 3, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY SPESUTIA EPISCOPAL | | | | 23d. LOCATION CITY OR TOWN PERRYMAN COUNTY HARFORD STATE MD | | | |
| 24. FUNERAL DIRECTOR NAME TARRINK FUNERAL HOME, P.A. ADDRESS 333 S. PARK ST. | | | | 25a. DATE RECEIVED BY REGISTRAR JUL 5 1981 | | | | 25b. REGISTRAR'S SIGNATURE | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 1 6 1 0 9 | | | |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| MAYME HAWES FLOYD | | | | June 18 81 12 ⁴⁵ PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | White | | 8 28 1897 | | 83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| W VA | | USA | | | | Harford MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Harford | | Harford Memorial Hosp. | | Homemaker | | Home | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Md. | | Harford | | Aberdeen | | 621 Beards Hill Rd. | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| WILLIAM HAWES | | | | SARAH ALLEN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | 213-12-7784T | | Helena L. Childers - 621 Beards Hill Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiac Decomposition | | | | | | | |
| 4292 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) Constrictive heart failure | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) Arteriosclerotic cardiovascular disease | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| Electrolyte imbalance | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-11 19 81, to 6-18 19 81, that (I) (we) last saw the deceased alive on 6-18 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| | | | | | | 6/18/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| H. James Kohn M.D. | | | | 315 So. Union Ave Harford Grace Md. 21078 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| TRANSFER/BURIAL | | | | 6/20/1981 | | Woodlawn Cemetery | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| TARRING FUNERAL HOME | | | | P.A. ABERDEEN, MD. | | JUN 22 1981 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | | | T. J. HARRIS | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VRA 15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 16110 | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Leslie Leonard Harris | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 6-23-81 | |
| 1. SEX M. 4. RACE W. 5. DATE OF BIRTH 2-28-900 81 YRS. 6. AGE (IN YEARS) 81 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | 2b. HOUR 11 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 2c. DATE PRONOUNCED DEAD 6-28-81 12 M | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD | | | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH Harford 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hos. 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Sec. Railroad Boss 12b. KIND OF BUSINESS OR INDUSTRY Ret. | | | | | | | | | | | |
| 13a. STATE Md. 13b. COUNTY Cecil 13c. CITY OR TOWN Kimber 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 13e. STREET ADDRESS Box 192 - Pearl St. | | | | | | | | | | | |
| 14. FATHER'S NAME John Harris 15. MOTHER'S MAIDEN NAME Phoebe Rial | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 717-07-5306 17. INFORMANT Herrel Curry Jr. Rising, Sun Md ADDRESS | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) CORONARY Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASUUD DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Louis E. Renjel TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER DATE SIGNED 6-23-81 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) LOUIS E. RENJEL ADDRESS 464 Alliance St. Harford | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL 23b. DATE 6-28-81 23c. NAME OF CEMETERY OR CREMATORY Oxford Cem. 23d. LOCATION CITY OR TOWN COUNTY STATE Oxford-Chestertown Pa | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Simon E. McHenry ADDRESS Rising Sun, Md 25a. DATE REC'D. BY REGISTRAR JUN 25 1981 25b. REGISTRAR'S SIGNATURE Simon E. McHenry | | | | | | | | | | | |

MEDICAL CERTIFICATION

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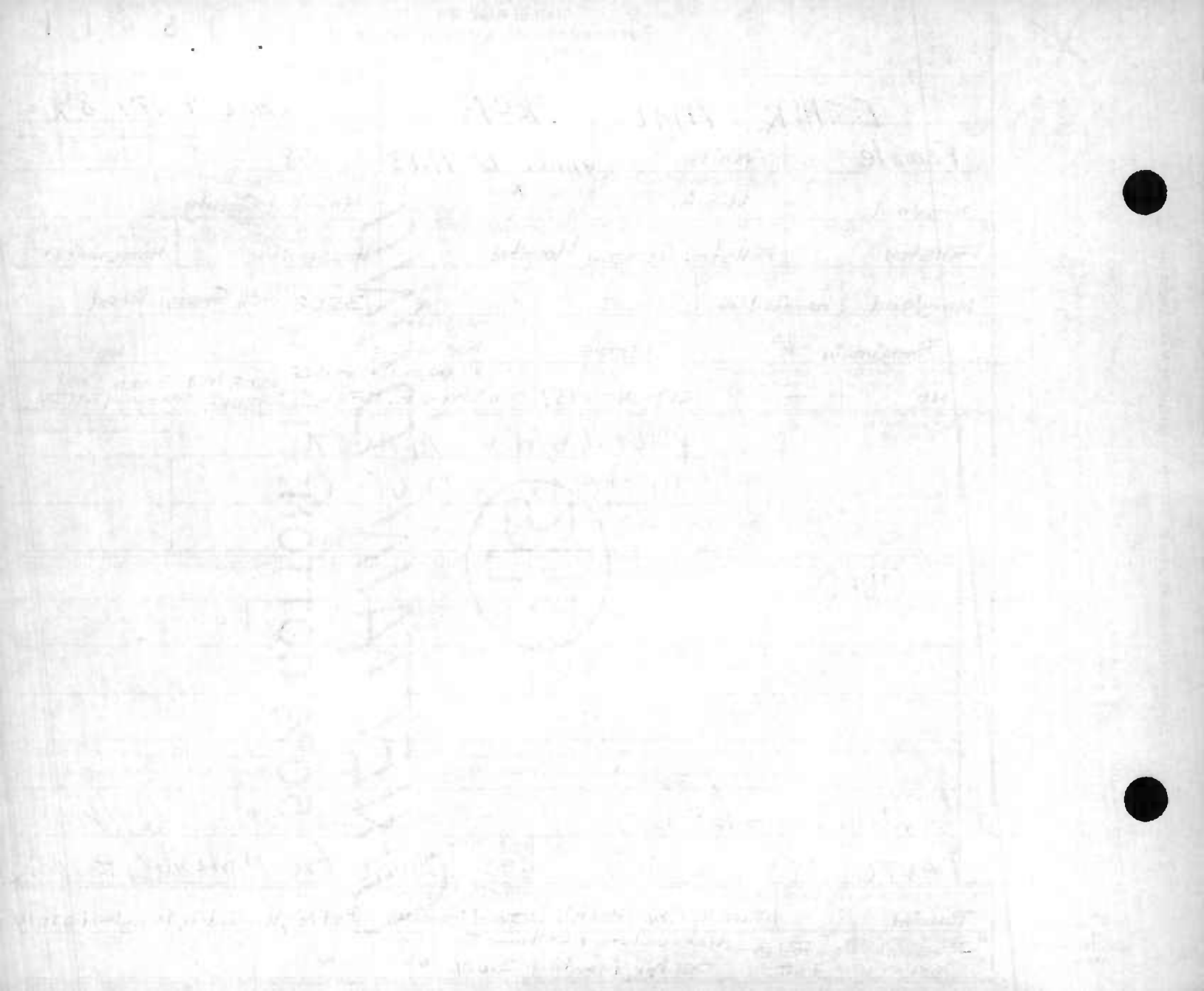
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ESTHER MAE HECK | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JUNE 9 1981 | | | | | 2b. HOUR 8:45 M |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR MAR. 6 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. | | | | |
| 10. CITY OR TOWN OF DEATH Fallston | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Homemaker | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET ADDRESS 3508 Mill Green Road |
| 13a. STATE Maryland | | 13b. COUNTY Harford Co. | | 13c. CITY OR TOWN Street | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN F. Temple | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine LEE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) — | | 17. INFORMANT (husband) 452-5015 ADDRESS 3508 Mill Green Road Steele, Maryland 21154 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY ARREST 1629 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC LUNG CA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) COPD | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Dante Monakil, M.D. | | | | | DEGREE M.D. | | | 22c. DATE SIGNED 6/9/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL, M.D. | | | | | 22e. ADDRESS 622 S. Union Ave Anne Arundel, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE June 11, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland 21014 | | | | |
| 24. FUNERAL DIRECTOR Joseph William Foster Jacobsville, Md | | | | | 25. DATE REC'D. BY REGISTRAR JUN 12 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 1 | 6 | 1 | 2 |
|---|--|--|--|---|--|---|--|--|--|--|---|--|---|---|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) THE ARTHUR FRANCIS HENRY | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 6/2/81 | | | | 2b. HOUR 4:00A.M. | | | | |
| 3. SEX male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 01 10 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Joppa | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 205 Frazier Court | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Military Investigator US-govt | | 12b. KIND OF BUSINESS OR INDUSTRY Ret. | | | | | | |
| 13a. STATE Maryland | | | | | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Joppa | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 205 Frazier Court | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Sterling Price Henry | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jesse McQueen | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR SERVICE Yes WWII, Korea | | | | 16b. SOCIAL SECURITY NO. Vietnam 057 07 7218 | | 17. INFORMANT ADDRESS Mrs. Jewell L. Henry, Joppa town, Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Oat cell carcinoma - lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 mos. | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Dec. 19 80, to June 2, 19 81, that (1) (we) last saw the deceased alive on May 25, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE DE HOGGE | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 6-2-81 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. E. HOGGE | | | | | | 22e. ADDRESS 22 S Greene St. Baltimore Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE June 5, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION Arlington-Arlington-Va. | | | | | | |
| 24. FUNERAL DIRECTOR Howard K. McComas III | | | | | | 24b. ADDRESS Abingdon, Md. | | 25a. DATE REC'D. BY REGISTRAR JUN 5 1981 | | 25b. REGISTRAR'S SIGNATURE Fitzpatrick | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 1 1 3

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) David LEAL Hill | | | 2a. DATE OF DEATH MONTH DAY YEAR 6 23 81 | | 2b. HOUR 8:55 PM |
| 3. SEX MALE | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 05 31 09 | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Illinois | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD. | | |
| 10. CITY OR TOWN OF DEATH Fallston | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Biochemist | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. |
| 13a. STATE Maryland | | | 13b. COUNTY Harford Co. | 13c. CITY OR TOWN Bel Air | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Dr. William Kuhns Hill | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katharine Griffith | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 353-20-0557 | 17. INFORMANT (WIFE) 838-7507 Mrs. Irma L. Hill | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Ventricular Fibrillation</u> (c) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/23</u> 19 <u>81</u> , to <u>6/23</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>6/23</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Joseph Reinhardt | | | | 22c. DATE SIGNED 6-24-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH A. REINHARDT, M.D. | | | | 22e. ADDRESS 2003 Rock Spring Road, Forest Hill, Maryland 21050 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE June 26, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland | | 23e. DATE REC'D. BY REGISTRAR JUN 25 1981 | | | |
| 24. FUNERAL DIRECTOR Joseph William Foster | | 25. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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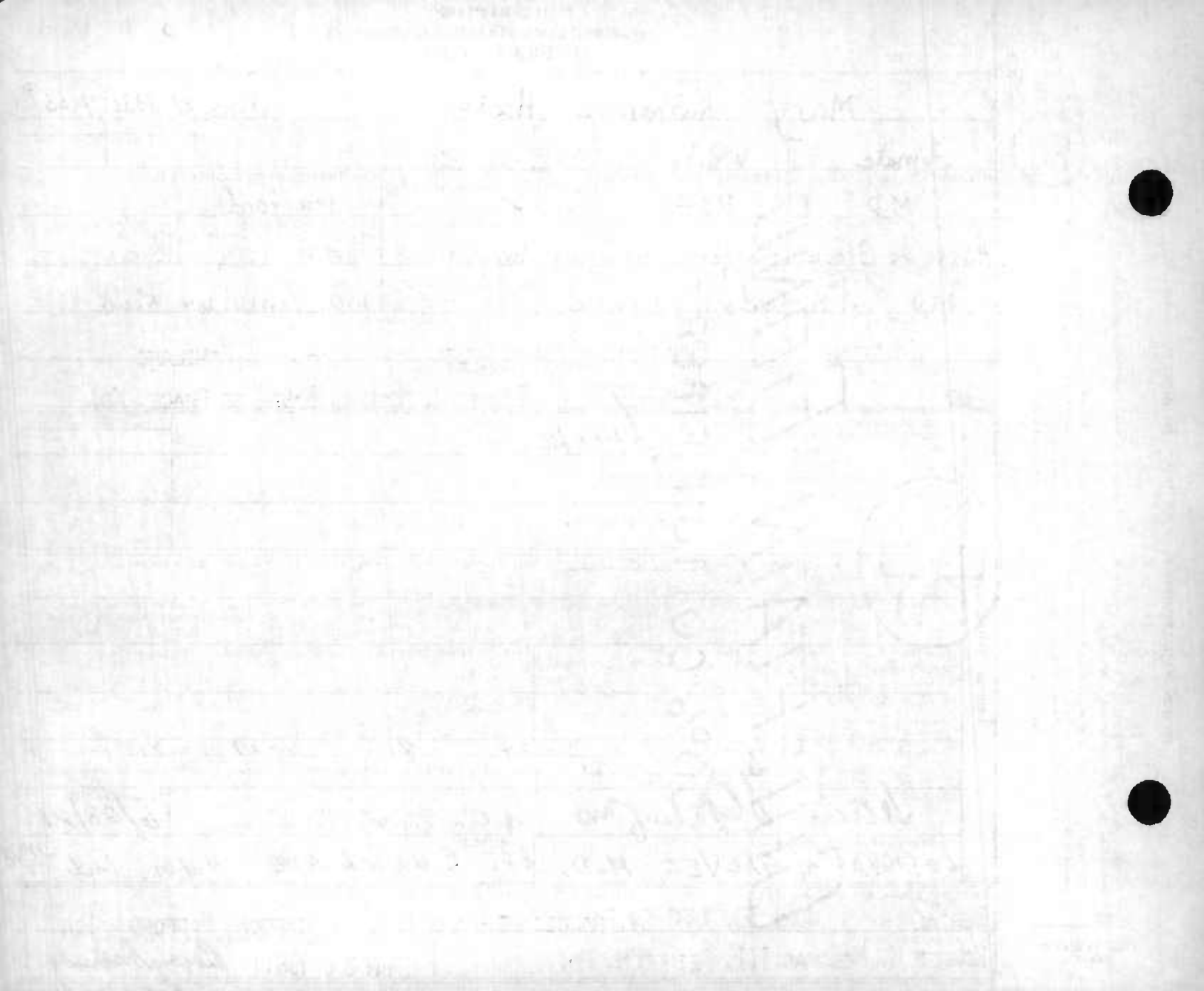
1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 1 1 4

REG. NO.

| | | | | | | | |
|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mary Katherine Hooker | | | 2a. DATE OF DEATH MONTH DAY YEAR June 27 1981 | | | 2b. HOUR P 7:05 P | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR SEPT. 18, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | | | |
| 10. CITY OR TOWN OF DEATH Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POSTAL CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY US-GOVT. RET. | |
| 13a. STATE MD | | 13b. COUNTY Harford | 13c. CITY OR TOWN Edgewood | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1801 Vanbibber Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JEREMIAH -- SULLIVAN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN -- HAVILAND | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215-44-0964 | | 17. INFORMANT ADDRESS EDWARD J. HOOKER, HAVRE DE GRACE, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-24</u> , 19 <u>81</u> , to <u>6-27</u> , 19 <u>81</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>6-27</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Leticia S. Galvez</u> | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 6/28/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LETICIA S. GALVEZ, M.D. | | | | 22e. ADDRESS 625 S. UNION AVE H.d.G., Md. 21078 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JUNE 30, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY ST. FRANCIS DE SALES CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE ABINGDON HARFORD MD. | |
| 24. FUNERAL DIRECTOR HOWARD K. MCCOMAS III, ABINGDON, Md. | | | | 25a. DATE REC'D. BY REGISTRAR JUN 30 1981 | | 25b. REGISTRAR'S SIGNATURE <u>Leticia S. Galvez</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 1 6 1 1 5 REG. NO. | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) NORMA ETHEL HOWELL | | | | 2a DATE OF DEATH MONTH DAY YEAR 6 17 81 | | | | 2b HOUR 11³⁰ PM | | | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR 9 20 12 | | 6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD. | | | | | |
| 10 CITY OR TOWN OF DEATH FALSTON | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALSTON GENERAL HOSP. | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b KIND OF BUSINESS OR INDUSTRY --- | | | |
| 13a STATE MARYLAND | | | | 13b COUNTY HARFORD | | 13c CITY OR TOWN BEL AIR | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS 713 CEDAR LANE | |
| 14 FATHER'S NAME FIRST MIDDLE LAST ELZA EDGAR HOWELL | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORA ELLEN SETTLE | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b SOCIAL SECURITY NO. 220-24-4565 | | 17 INFORMANT ADDRESS MRS. E. RUBY HOOKER, BEL AIR, MD. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute respiratory failure 4960 DUE TO, OR AS A CONSEQUENCE OF (b) chronic obstructive lung disease DUE TO, OR AS A CONSEQUENCE OF (c) congestive heart failure. Anaemia | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a DATE OF OPERATION 4/7/81 | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED prolonged ventricular support | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 6/14/81 19 81 to 6/17/81 19 81 , that (I) (we) last saw the deceased alive on 6/17/81 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE Asma Luis | | | | DEGREE | | | | 22c DATE SIGNED 6/17/81 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) A. B. MARTINS MD | | | | 22e ADDRESS FALSTON GENERAL HOSPITAL | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL SPECIFY BURIAL | | | | 23b DATE JUNE 20, 1981 | | 23c NAME OF CEMETERY OR CREMATORY MOUNTAIN CHRISTIAN CEM. JOPPA | | 23d LOCATION CITY OR TOWN COUNTY STATE HARFORD MD. | | | |
| 24 FUNERAL DIRECTOR NAME HOWARD K. McCOMAS III, ABINGDON, MD. | | | | 25a DATE REC'D. BY REGISTRAR JUN 19 1981 | | 25b REGISTRAR'S SIGNATURE Richard McBratney | | | | | |

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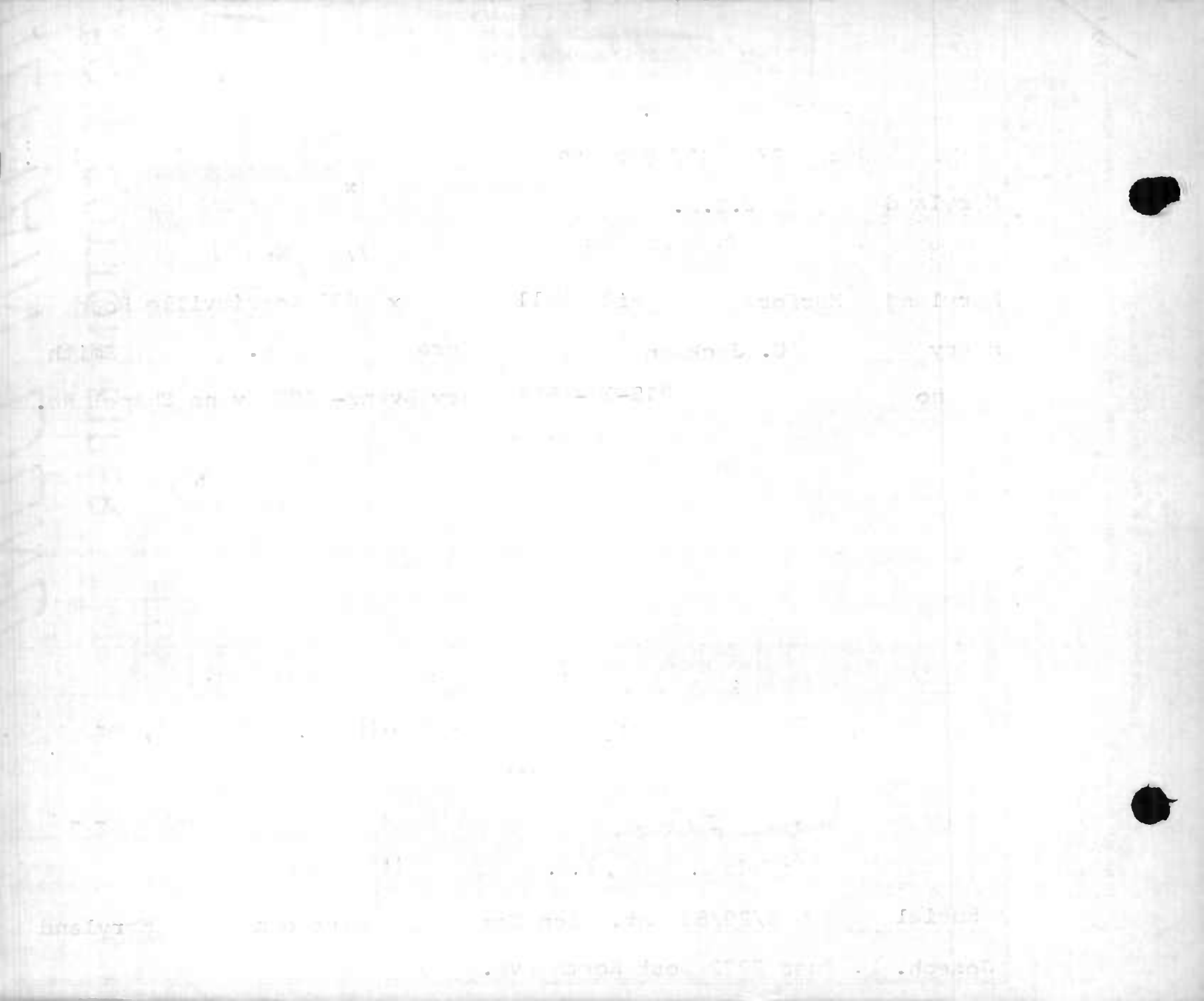
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) James M. Jackson | | | | | | | | | | 2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 6 7 19 81 | |
| 3. SEX Male 4. RACE Black 5. DATE OF BIRTH MONTH DAY YEAR 2/ 12/1922 6. AGE (IN YEARS LAST BIRTHDAY) 59 7. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 2b. HOUR M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. BALTIMORE CITY OR COUNTY OF DEATH Harford County | | | | | | | | | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 7 19 81 | |
| 10. CITY OR TOWN OF DEATH White Hall 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4833 Norrisville Road 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | 2d. HOUR 10:30 P.M. | |
| 13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN White Hall 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 4833 Norrisville Road | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry G. Jackson 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora W. Smith | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no 16b. SOCIAL SECURITY NO. 215-32-0805 17. INFORMANT ADDRESS Mary Evans-4102 Evans Chapel Rd. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke Inhalation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR 9:00 MONTH DAY YEAR 6 7 19 81 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject in house trailer fire | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house trailer 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4833 Norrisville Rd., White Hall, Harford County Md. | | | | | | | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 6-8-81 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. ADDRESS 111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 6/20/81 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem 23d. LOCATION CITY OR TOWN COUNTY STATE Lansdown Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Joseph. L. Russ 2222 West North Ave. 25a. DATE REC'D. BY REGISTRAR JUN 29 1981 25b. REGISTRAR'S SIGNATURE Henry McCreary | | | | | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 1 6 1 1 7
CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1- FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Roosevelt Oliver Jenkins | | 2a. DATE OF DEATH MONTH DAY YEAR June 10, 1981 | |
| 3. SEX Male | | 2b. HOUR 6 AM | |
| 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR April 15, 1921 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 60 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | |
| 10. CITY OR TOWN OF DEATH Harve de Grace | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BRICKMAN | | 12b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR | |
| 13a. STATE MD | | 13b. COUNTY HARFORD | |
| 13c. CITY OR TOWN Harve de Grace | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 614 GLEARD ST | | 14. FATHER'S NAME FIRST MIDDLE LAST Oliver Jenkins | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Snell | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | |
| 16b. SOCIAL SECURITY NO. 220-01-2321 | | 17. INFORMANT ADDRESS ELOISE Coleman Harve de Grace, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive atherosclerotic heart disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Joints | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-5 , 19 81 , to 6-10 , 19 81 , that (I) (we) last saw the deceased alive on 6-10 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Ann L. Wachsmann | | 22c. DATE SIGNED 6/10/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) I. Wachsmann MD | | 22e. ADDRESS Harve de Grace, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL | | 23b. DATE June 15, 1981 | |
| 23c. NAME OF CEMETERY OR CREMATORY St. James United | | 23d. LOCATION CITY OR TOWN COUNTY STATE Harve de Grace Harford, Md. | |
| 24. FUNERAL DIRECTOR NAME Obelia J. Bullard | | 25a. DATE REC'D. BY REGISTRAR JUN 15 1981 | |
| ADDRESS Harve de Grace, Md. | | 25b. DATE REC'D. BY REGISTRAR Harve de Grace, Md. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STANDARD FORM NO. 64
MAY 1962 EDITION
GSA GEN. REG. NO. 27

2

Page

June 12, 1961

Re: Chief Clerk

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY ELIZABETH KLAUENBERG | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 6 11 81 | | | 2b. HOUR 6⁰⁹ A.M. | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 12 09 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | | | |
| 10. CITY OR TOWN OF DEATH FALLSTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Kingsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 11203 Towood Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John F. Hoffert | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Bremmer | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 118-38-2330 | | 17. INFORMANT ADDRESS Theodore J. Klauenberg Towood Rd. 11203 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE 2500 DUE TO, OR AS A CONSEQUENCE OF (b) DIABETES MELLITUS SEPTIS DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) SEPTIS, RECENT ACUTE MI. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 20 May 19 81 , to 11 June 19 81 , that (we) last saw the deceased alive on 11 June 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Marilyn J. Macvey | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 11 June 81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARILYN J. MACVEY | | | | 22e. ADDRESS FALLSTON GEN Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6-15-81 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | | |
| 24. FUNERAL DIRECTOR NAME John C. Miller Inc. 6415 Belair Rd. | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR JUN 12 1981 | | 25b. REGISTRAR'S SIGNATURE Robert A. Brady | |

THE JOINT CHIEFS OF STAFF
WASHINGTON, D. C.
JAN 11 1964
MEMORANDUM FOR THE SECRETARY OF DEFENSE
SUBJECT: [Illegible]

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96. [Illegible]
97. [Illegible]
98. [Illegible]
99. [Illegible]
100. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

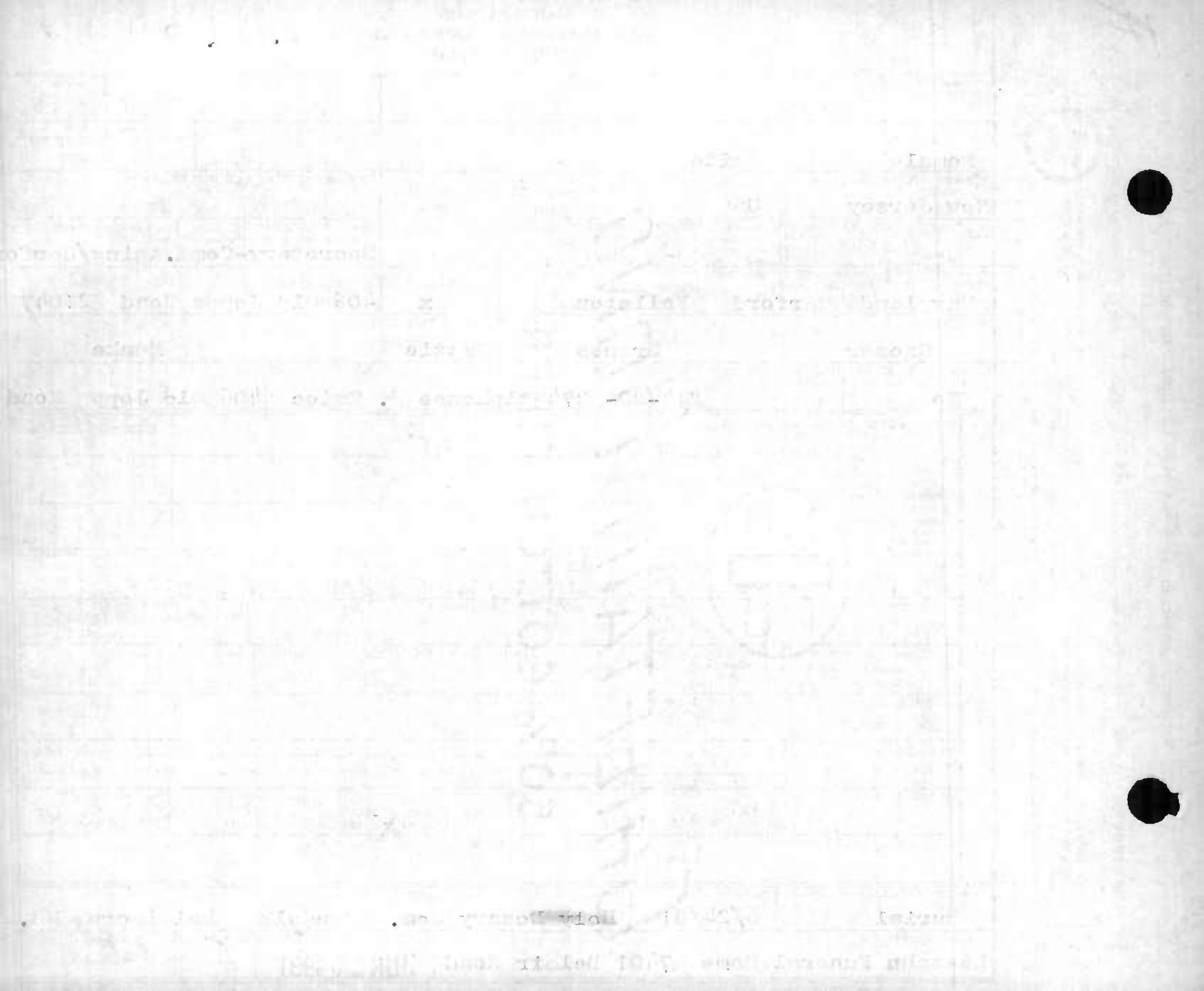
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1. 1 6 1 1 9

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) NORMA HARRIETTE KMEC | | | 2a. DATE OF DEATH MONTH DAY YEAR 6 20 81 | | | 2b. HOUR 98 ⁵ M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 4 7 28 | | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH FALLSTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary-Comm. | |
| 12b. KIND OF BUSINESS OR INDUSTRY Aging/Harford | | 13a. STREET ADDRESS 406 Old Joppa Road | | 21047 | | | |
| 13a. STATE Maryland | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Fallston | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Caeser Krauss | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Menke | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-20-8274 | | 17. INFORMANT ADDRESS Alphonse W. Kmiec 406 Old Joppa Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4375 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). MALIGNANT MELANOMA / WIDESPREAD METASTASES | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE VM Abhyankar | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 26 June 81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/24/81 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Baltimore Md. | |
| 24. FUNERAL DIRECTOR NAME Lassahn Funeral Home | | | | ADDRESS 7401 Belair Road | | 25a. DATE REC'D. BY REGISTRAR JUN 25 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Rafaela M. M... | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 1 6 1 2 0 | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Curtis W. Lampson | | | | 2a. DATE OF DEATH MONTH DAY YEAR June 30, 1981 | | 2b. HOUR 10:05 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 4 14 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 74 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Dakota | | 7b. CITIZEN OF WHAT COUNTRY? USA. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | |
| 10. CITY OR TOWN OF DEATH Havre de Grace | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Screen Tist | | 12b. KIND OF BUSINESS OR INDUSTRY App. Wd. | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN Maryland Harford Havre de Grace | | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS 135 Pulaski Highway | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bert Lampson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Worsell | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE SERVICE; IF NO, GIVE WAR OR DATES) NO | | | |
| 16b. SOCIAL SECURITY NO. 074-10-9861 | | 17. INFORMANT NAME ADDRESS Miles H. Lampson, Havre de Grace, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4416 Thrombosis of Mesenteric Artery DUE TO, OR AS A CONSEQUENCE OF (b) Large Vessel Atherosclerosis & Aortic Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) Tumor of Left Kidney APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ↓ 3 yrs 1 year | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION 3-23-81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Tumor of Left Kidney | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3-23-81 6-30-81 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-23-81 to 6-30-81, and that (I) (we) last saw the deceased alive on 3-23-81 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (If (we) did (did not) view the body after death). | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN (TYPE OR PRINT) Peter P. Rodman, M.D. | | | | 22c. DATE SIGNED 7-1-81 | | 22d. ADDRESS 8 Law St. Aberdeen, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/3/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Grace Wesleyan Ch. - Aberdeen, Md. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen, Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Tarrance Funeral Home - Aberdeen, Md. 21001 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 7 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

BP

REBEL COLLECTION

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) George Melvin Lester | | | 2a. DATE OF DEATH MONTH DAY YEAR June 7, 1981 | | | 2b. HOUR 9⁴⁵ A.M. | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 8 31 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. | | | |
| 10. CITY OR TOWN OF DEATH Fallston, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK, PLANT OR TRADING LIFE) Retired Mine Worker | | 12b. KIND OF BUSINESS OR INDUSTRY CHEMICAL | |
| 13a. STATE Md. | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Joppa | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1106 Old Mountain Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GEORGE MARION LESTER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RHODA CATHERINE LOWE | | | | 16. ADDRESS 8 ARDMORE ROAD | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 235-09-3269 | | 17. INFORMANT MARSHALL V. LESTER, NEWARK, DEL. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 4920 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Acute & Chronic Resp. Failure (c) Severe pulmonary emphysema APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Severe Pneumonia (2 1/2 yrs in coal mine) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from May 30, 1981 to June 6, 1981 , that (1) (we) lost saw the deceased alive on June 6, 1981 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Albert S. C. Sun, M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert S. C. Sun, M.D. | | | | 22e. ADDRESS 1800 Harford Road Fallston 21047 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JUNE 9, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY BELAIR MEM. GARDENS | | 23d. LOCATION CITY OR TOWN COUNTY STATE BELAIR HARFORD MD. | | | |
| 24. FUNERAL DIRECTOR NAME HOWARD K. McCOMAS III, ABINGDON, MD. | | | | 25a. DATE REC'D. BY REGISTRAR JUN 9 - 1981 | | 25b. THIS CARD IS Not to be used | | | |

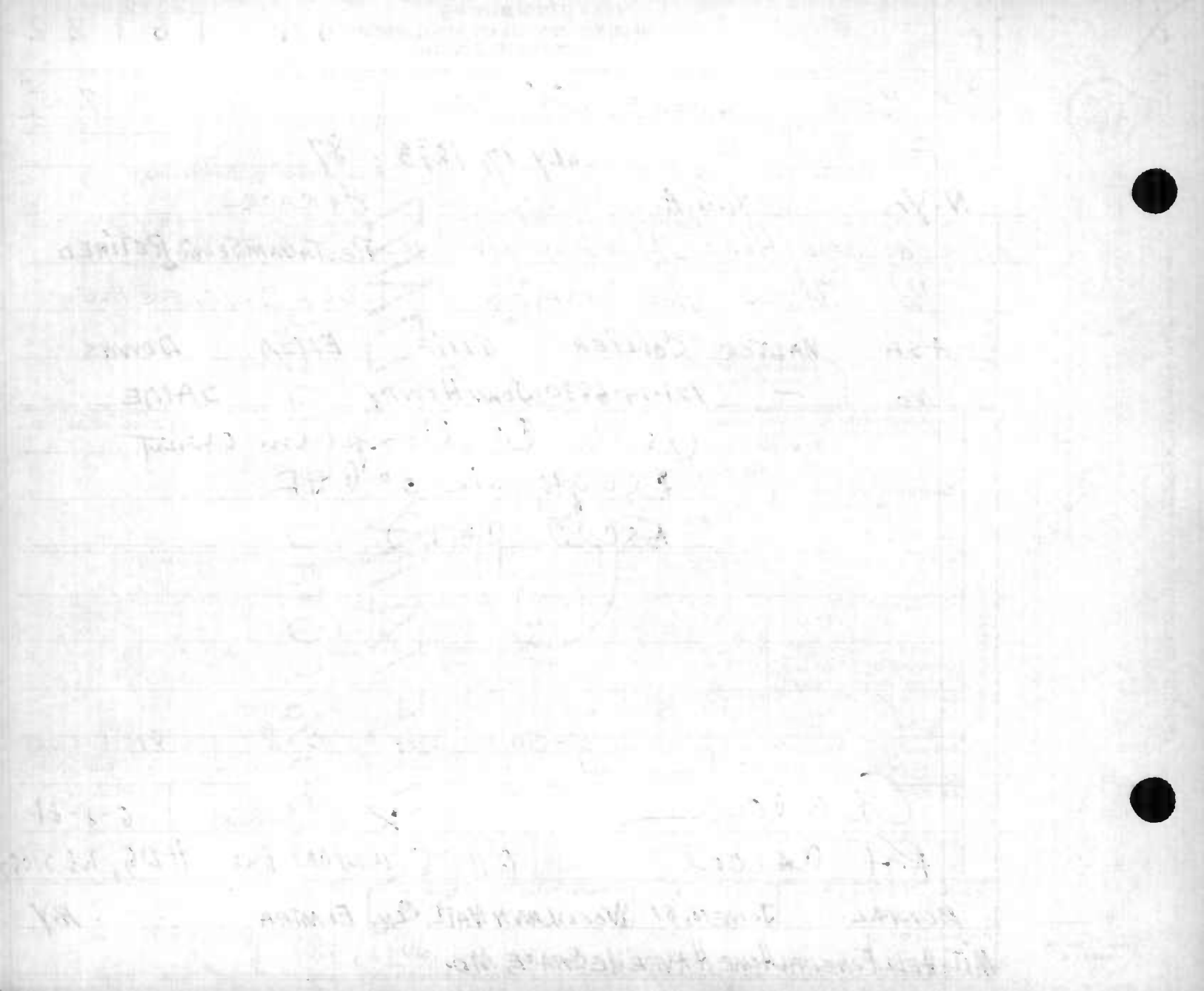
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| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 1 6 1 2 2 REG. NO. | | | |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH ROWENA LIVINGSTON | | | | 2a. DATE OF DEATH MONTH DAY YEAR 6-8-81 | | | | 2b. HOUR A 7:05 M | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR JULY 17, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD | | | | | |
| 10. CITY OR TOWN OF DEATH HARFORD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RESTAURANT SERVICE | | 12b. KIND OF BUSINESS OR INDUSTRY RETIRED | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE MD | | | | 13b. COUNTY HARFORD | | 13c. CITY OR TOWN HARFORD | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ASA WALTER COLLIER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OLLIE ELIZA DOWNS | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 121-14-6830 | | 17. INFORMANT JOAN HENRY | | ADDRESS SAME | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Cardiac-pulm. arrest 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Arrhythmia 2° CHF DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD, CAD | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-30, 19 81, to 6-8, 19 81, that (I) (we) last saw the deceased alive on 6-8, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE A.H. CALON | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 6-8-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.H. CALON | | | | | | 22e. ADDRESS 611 S. UNION Ave HDS, NO. 21087 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE JUNE 10, 81 | | 23c. NAME OF CEMETERY OR CREMATORY WOODLAWN NATL. CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE ELMIRA N.Y. | | | |
| 24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME, HARFORD, MD. | | | | | | 25. DATE REC'D. BY REGISTRAR JUN 10 1981 | | 25. REGISTRAR'S SIGNATURE | | | |



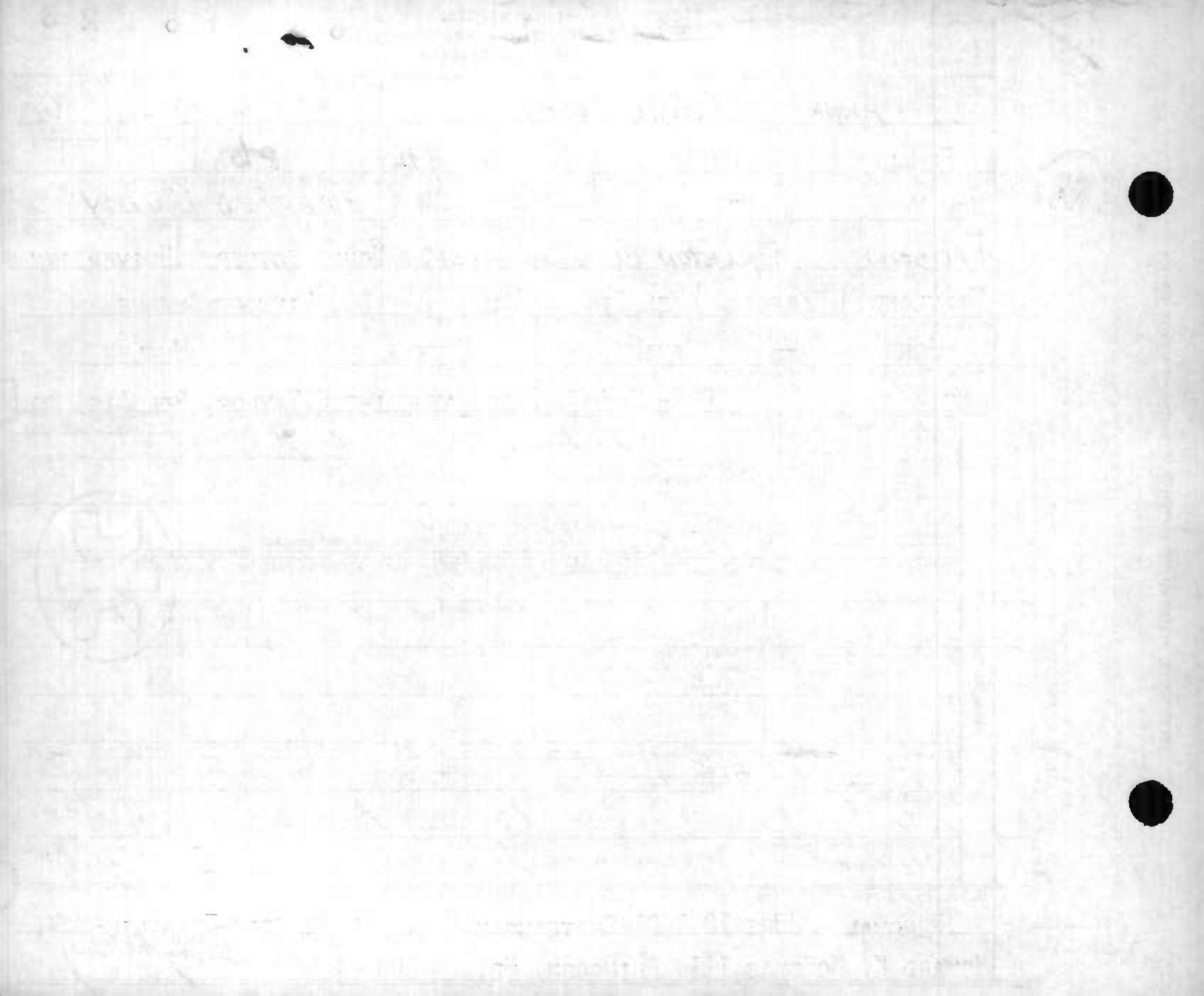
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 6 1 2 3

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| ANNA | | 6 10 81 | | 6 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| FEMALE | | WHITE | | 10 31 94 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| NEW YORK | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| FAUSTON | | FAUSTON GENERAL HOSP. | | HOUSE MOTHER | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MARYLAND | | HARFORD | | BEL AIR | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16. STREET ADDRESS | |
| JOHN -- NAVIN | | KATE -- WHALEN | | 602 LINWOOD AVENUE | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 098-22-7008 | | MRS. KATHERINE F. TAYLOR, BEL AIR, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest, Asystole</u> 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sepsis</u> (c) <u>Bilateral Pneumonia</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>5/17</u> 19 <u>81</u> to <u>6/10</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>6/10</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Andrew Nowakowski MD</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 6/10/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew Nowakowski MD | | 22e. ADDRESS 215 Shamrock Rd, Bel Air MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| REMOVAL | | JUNE 10, 1981 | | CHATEAUGAY F.H. CHATEAUGAY-FRANKLIN-N.Y. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. THIS PART IS FOR THE STATE | |
| HOWARD K. McCOMAS III, ABINGDON, MD. | | JUN 12 1981 | | [Signature] | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 5. SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M/7/77

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|-------------------------------------|--|--|--|----------------|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST THOMAS | | MIDDLE EDWARD | | LAST LUND | | 2a. DATE KNOWN OF DEATH ESTIMATED | | MONTH 6 | | DAY 22 | | YEAR 81 | | 3a. HOUR 4 | | 3a. HOUR AM | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH AUG DAY 19 YEAR 1915 | | 6. AGE (IN YEARS) LAST BIRTHDAY 65 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 6/22/81 | | 3b. HOUR 5 | | 3b. HOUR AM | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH EDGEWOOD | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1133 CHIPPER DRIVE | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHIEF ACCOUNTANT | | 12b. KIND OF BUSINESS OR INDUSTRY CEMENT | | | | | | | | | | | | | |
| 13a. STATE MARYLAND | | 13b. CITY OR TOWN HARFORD | | 13c. CITY OR TOWN EDGEWOOD | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1133 CHIPPER DRIVE | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST PETER | | MIDDLE JOHANNSON | | LAST LUND | | 15. MOTHER'S MAIDEN NAME FIRST GRACE | | MIDDLE -- | | LAST ANDERSON | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 113-05-9408 | | 17. INFORMANT ADDRESS MRS. MARJORIE LUND, EDGEWOOD, Md. | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>COPD - ASCVD</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Luis E. Renteria | | | | M.D. DEPUTY MEDICAL EXAMINER | | | | DATE SIGNED 6/22/81 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) LUIS E. RENTERIA, MD | | | | ADDRESS 464 ALLIANCE ST. HARVET DE GRACE MD 21078 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL | | | | 23b. DATE JUNE 22, 1981 | | | | 23c. NAME OF CEMETERY OR CREMATORY FLYNN FUNERAL HOME | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE FORDS, MIDDLESEX, NEW JERSEY | | | | | | | |
| 24. FUNERAL DIRECTOR NAME HOWARD K. McCOMAS III, ABINGDON, Md. | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR JUN 23 1981 | | | | REGISTRAR'S SIGNATURE [Signature] | | | | | | | |

MEDICAL CERTIFICATION

THANKS FOR THE
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U.S. AIR FORCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 1 1 6 1 2 5 | | | | | |
| CERTIFICATE OF DEATH | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ANN Edythe HARDY Maschke | | | | | 2a. DATE OF DEATH MONTH DAY YEAR June 13, '81 | | | 2b. HOUR 8:20 P.M. | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 8 24 24 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | | | | |
| 10. CITY OR TOWN OF DEATH FALLSTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FINANCE DEPT. | | 12b. KIND OF BUSINESS OR INDUSTRY HAR. Co. Govt. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY HARFORD | | 13c. CITY OR TOWN FALLSTON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 409 WHITAKER MILL RD. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST RUFUS HARDY | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH TURNER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | | | 16b. SOCIAL SECURITY NO. 213-20-0286 | | 17. INFORMANT (HUSBAND) ADDRESS GEORGE S. MASCHKE SAME AS #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4920 Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute and chronic Renal failure 2-3 yrs DUE TO, OR AS A CONSEQUENCE OF (c) Severe bullous emphysema PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: with Acute and chronic bronchopneumonia / Bronch asthma | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 24, 1981, to June 13, 1981, that (I) we lost s/he the deceased alive on June 13, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Albert S.C. Sun, M.D. | | | | | DEGREE M.D. | | 22c. DATE SIGNED June 13, 81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert S.C. SUN, M.D. | | | | | 22e. ADDRESS 1800 Harford Rd. Fallston 21047 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 6/16/81 | | 23c. NAME OF CEMETERY OR CREMATORY BELAIR MEM. GARDENS | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BELAIR HARFORD MD. | | | |
| 24. FUNERAL DIRECTOR NAME E. BARNES FLEMING FUNERAL SERVICE | | | | | ADDRESS 21018 BENSON, MD. | | 25a. DATE REC'D. BY REGISTRAR JUN 16 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

BP

Photocopy

JUN 1 2 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|---|--|--|---|--|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. 8116126 | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) RAYMOND E MOORE, Sr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 6 15 81 | | 2b. HOUR 1:30 P.M. | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 8 27 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 9. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. | | | | |
| 12. CITY OR TOWN OF DEATH Fallston | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | | 15. KIND OF BUSINESS OR INDUSTRY | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADDRESS) 16a. STATE Maryland | | | 16b. COUNTY Harford | | 16c. CITY OR TOWN Belair | | 16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 16e. STREET ADDRESS 643 S. Atwood Road | |
| 17. FATHER'S NAME FIRST MIDDLE LAST John Henry Moore | | | | | 18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Perser | | | | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND OR UNKNOWN) No | | | 20. SOCIAL SECURITY NO. 212-10-81904 | | 21. INFORMANT ADDRESS Kenneth Holloway 33 Oakway Road | | | | | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell CA Lung with pleural 1629 DUE TO, OR AS A CONSEQUENCE OF Effusion. Anaemia (b) DUE TO, OR AS A CONSEQUENCE OF Histoplasmosis. (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 23. DATE OF OPERATION | | 24. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 25. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 26. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 28. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 30. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 31. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 32. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 33. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 34. SIGNATURE B. PAREKH MD. | | | | | 35. DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 36. DATE SIGNED 6-15-81 | | | |
| 37. PHYSICIAN'S NAME (TYPE OR PRINT) B. PAREKH MD. | | | | | 38. ADDRESS 1131 Bel Air Rd. Bel Air MD. 21014. | | | | | |
| 39. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 40. DATE 6/18/81 | | 41. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park | | 42. LOCATION CITY OR TOWN COUNTY STATE Parkville Baltimore Md. | | 43. DATE REC'D. BY REGISTRAR JUN 19 1981 | | |
| 44. FUNERAL DIRECTOR NAME Lassahn Funeral Home | | | | | 45. ADDRESS 7401 Belair Road | | 46. REGISTRAR'S SIGNATURE [Signature] | | | |

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Harvard University

Department of Mathematics

Division of Physical Sciences

Office of the Dean

Harvard University

Division of Physical Sciences

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8116127 | |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) JOSEPH MORAWSKI Sr. | | | 2a. DATE OF DEATH 6 7 81 | | 2b. HOUR 10 ^{PM} |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 05 09 1907 | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | | |
| 10. CITY OR TOWN OF DEATH FALLSTON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON (GENEAL) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lithograph Super-CCC | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | | 13b. COUNTY Harford | 13c. CITY OR TOWN Fallston | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Martin Morawski | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Poleswski | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No Yes | | | 16b. SOCIAL SECURITY NO. 1927-1928 215-09-6305 | 17. INFORMANT Cecilia Morawski | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma 2028 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from September 19 26, to June 19 81, that (I) (we) last saw the deceased alive on May 26 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Martin D. Abelloff | | DEGREE MD | | 22c. DATE SIGNED 6/8/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN D. ABELLOFF | | 22e. ADDRESS Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 6/10/81 | 23c. NAME OF CEMETERY OR CREMATORY Highview Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Fallston Harford, Md. | |
| 24. FUNERAL DIRECTOR NAME E.F. Lassahn | | Kingsville, Md. 21087 | | 25a. DATE REC'D. BY REGISTRAR JUN 12 1981 | |
| 11750 Belair Rd | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

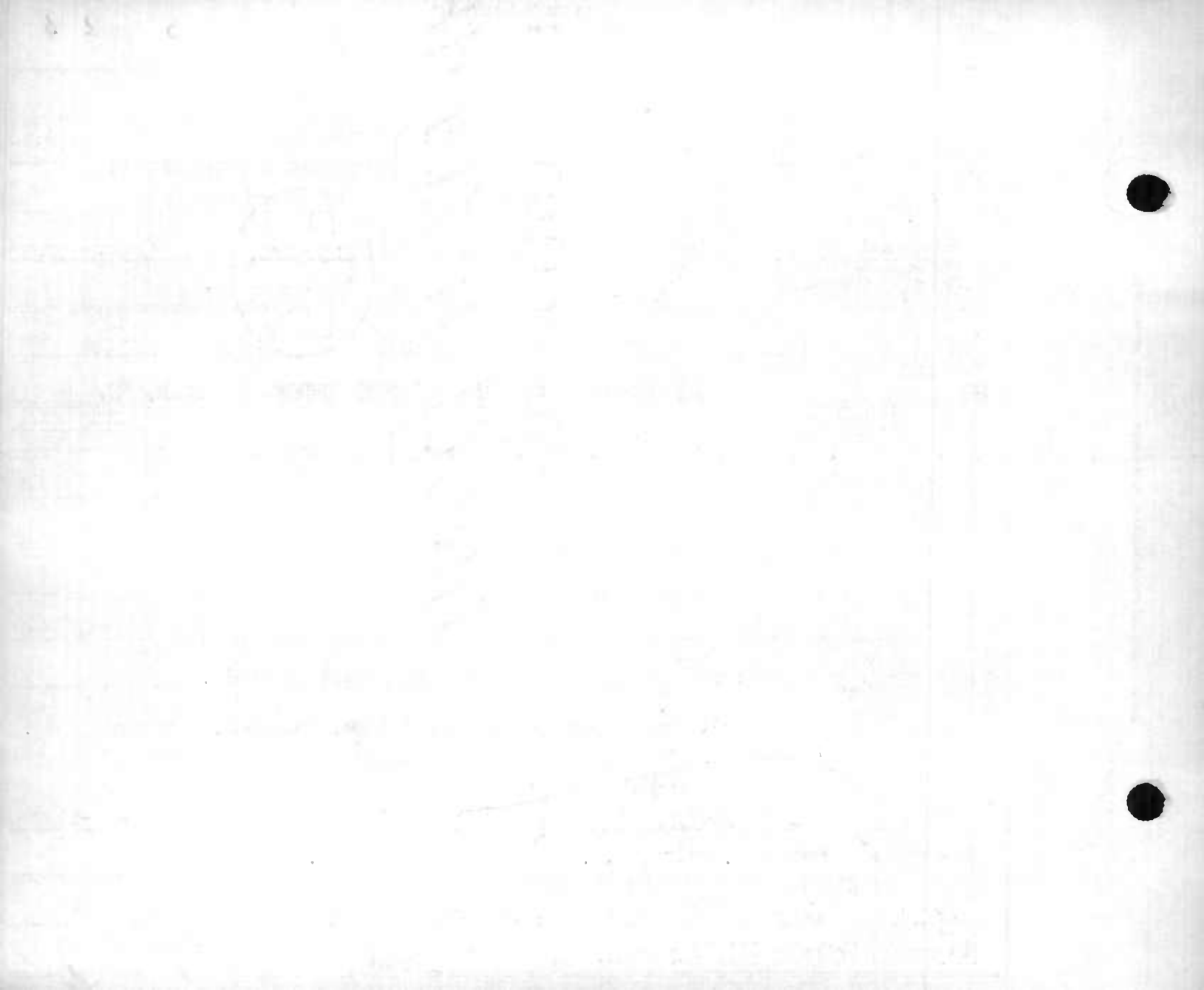
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

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(VR A) 5 ME (5)
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 16128 | |
|--|--|------------------|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GARY MICHAEL MORROW | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 28 19 81 | | 2b. HOUR M | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR JUNE 4, 1955 | | 6. AGE IN YEARS (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 26 YRS. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 28 19 81 | | 7d. HOUR 9:10 p M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 9. CITY OR TOWN OF DEATH Edgewood | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bush River Bridge (railroad tracks) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BRICKLAYER | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | | | | 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. CITY OR TOWN HARFORD 13c. CITY OR TOWN ABERDEEN | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 3402 PEBBLE DRIVE | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN PAUL MORROW | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROLINE KATHLEEN WEIMAN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-66-9476 | | | | 17. INFORMANT ADDRESS DEBORAH ANNE MORROW, ABERDEEN, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8059 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR XXXX MONTH DAY YEAR 7:55 P.M. 6-28-19 81 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by train. | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) railroad tracks | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Bush River Bridge, Edgewood, Harford Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Acc. Death <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| ACTUAL SIGNATURE <i>Thomas D. Smith</i> | | | | TITLE (SPECIFY) M.D. Deputy Chief | | | | MEDICAL EXAMINER DATE SIGNED 6-29-81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE JULY 1, 1981 | | | | 23c. NAME OF CEMETERY OR CREMATORY HARFORD MEM. GARDENS | | | |
| 23d. LOCATION CITY OR TOWN ALDINO | | | | COUNTY HARFORD | | | | STATE Md. | | | |
| 24. FUNERAL DIRECTOR NAME HOWARD K. McCOMAS III, ADDRESS ABINGDON, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 30 1981 | | 25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 1 | 1 | 6 | 1 | 2 | 9 |
|---|--|--|---|--|---|---|--|--|---|---|---|-----------------------------|-----------------------------------|-----------------------------|---|---|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ada L. Mullane | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 6 6 81 | | | 2b. HOUR 10:36a | | | |
| 3 SEX Female | | | 4 RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR 3 29 1890 | | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 91 | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisc. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Havre de Grace | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13b. STREET ADDRESS | | | |
| 13a. STATE Md. | | | 13b. COUNTY Harford | | | 13c. CITY OR TOWN Churchville | | | 13d. STREET ADDRESS 1205 Mystic Ct. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert Senninger | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linda M. Dean | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. 389 16 1864 | | | | | 17. INFORMANT ADDRESS (Son) Duane H. Roepke Same as #13e | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SHOCK</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| 4039 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>UREMIA</u> | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>NEPHROSCLEROSIS</u> | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>6/6</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Dante J. Monakel</i> | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 6/6/81 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MONAKEL, DANTE | | | | | | 22e. ADDRESS 622 S. Union Ave. Havre de Grace, Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 7JUN81 | | 23c. NAME OF CEMETERY OR CREMATORY Cratin & Ferris | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE West Chester, Pa. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Mitchell Funeral Home, Havre de Grace, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 10 1981 | | | | 25b. REGISTRAR'S SIGNATURE <i>Anthony...</i> | | | | | | |

| | | | |
|---------------|-------------------------|--------------|---------------|
| Female | White | 90-1800 | of |
| Wisc. | USA | E. X | Harold County |
| Wisc. is good | Children's Reading Room | Home Library | |
| Ed. Harold | Channahville | 1905 | Harold Co. |
| Liberty | Channahville | 1905 | Harold Co. |
| No | 1905 to 1906 | 1905 to 1906 | Harold Co. |

| | | | |
|--------------|--------------|--------------|--------------|
| 1905 to 1906 | 1905 to 1906 | 1905 to 1906 | 1905 to 1906 |
| 1905 to 1906 | 1905 to 1906 | 1905 to 1906 | 1905 to 1906 |
| 1905 to 1906 | 1905 to 1906 | 1905 to 1906 | 1905 to 1906 |
| 1905 to 1906 | 1905 to 1906 | 1905 to 1906 | 1905 to 1906 |
| 1905 to 1906 | 1905 to 1906 | 1905 to 1906 | 1905 to 1906 |
| 1905 to 1906 | 1905 to 1906 | 1905 to 1906 | 1905 to 1906 |
| 1905 to 1906 | 1905 to 1906 | 1905 to 1906 | 1905 to 1906 |
| 1905 to 1906 | 1905 to 1906 | 1905 to 1906 | 1905 to 1906 |
| 1905 to 1906 | 1905 to 1906 | 1905 to 1906 | 1905 to 1906 |
| 1905 to 1906 | 1905 to 1906 | 1905 to 1906 | 1905 to 1906 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 356-6666.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 1 3 0

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Margaret Mary Norton</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>June 29, 1981</i> | | 2b. HOUR <i>12 30</i> M |
| 3. SEX <i>Female</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>June 28, 1906</i> | 6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD. | | |
| 10. CITY OR TOWN OF DEATH <i>Harre de Grace</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Mem. Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Dental Asst.</i> | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md</i> 13b. COUNTY <i>Cecil</i> 13c. CITY OR TOWN <i>Port Deposit</i> | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS <i>1867 Hopewell Rd.</i> | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <i>Richard Norton</i> | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <i>Mary Cooney</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>213-20-3633</i> | | 17. INFORMANT <i>Marydretabradley, 1867 Hopewell Road, Port Deposit</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>4039 Cardiac Decompensation</i> IMMEDIATE CAUSE (a) <i>H.A.S. C.U.D.</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> <i>4 years</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>C.V.A. + U.T.I.</i> | | | | | |
| 19a. DATE OF OPERATION <i>—</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NEEDED MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>—</i> | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>—</i> | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>—</i> | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>April 22, 1981</i> to <i>June 29, 1981</i> , that (I) (we) last saw the deceased alive on <i>June 29, 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Edward C. Loo, M.D.</i> | | DEGREE <i>M.D.</i> | | 22c. DATE SIGNED <i>6/29/81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>EDWARD C. LOO, M.D.</i> | | 22e. ADDRESS <i>Harre de Grace, Ind. 21078.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>July 1, 1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i> | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore City Md.</i> | | 24. FUNERAL DIRECTOR <i>E. A. Patterson & Son, Perryville, Md.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JUL 6 1981</i> | |
| 25b. REGISTRAR'S SIGNATURE <i>Jeffrey M. [Signature]</i> | | | | | |

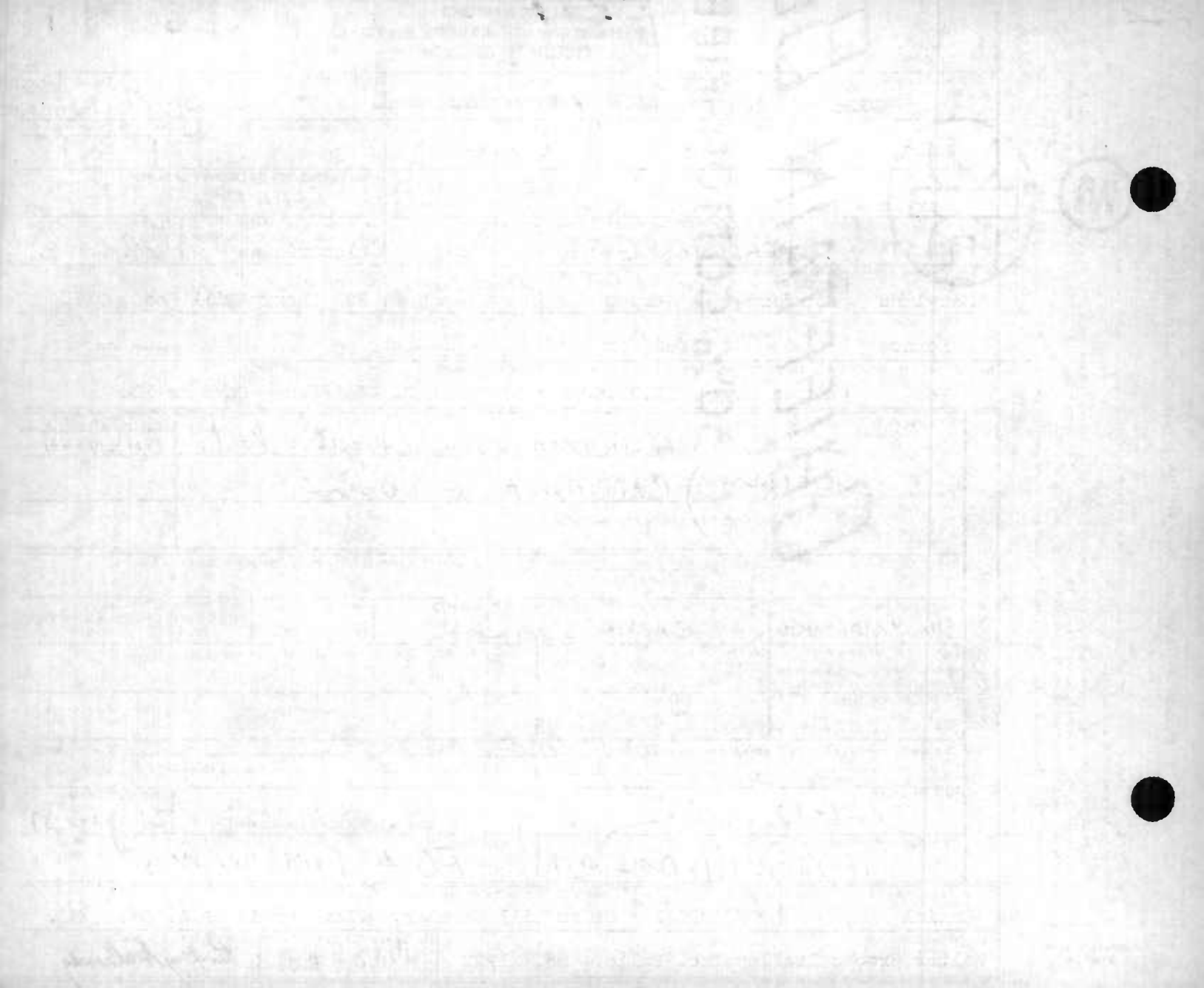
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 1 3

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) HORACE LEWIS HORACE PFEIFFER | | 2a. DATE OF DEATH MONTH DAY YEAR 6 21 81 | | 2b. HOUR mid- 12 night | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9/20/1930 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH FALLSTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSP | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't. | | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Street | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 503 Cherry Hill Road 21154 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Horace Pfeiffer | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Norfoll | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea Navy 212.28.6099 | | 17. INFORMANT ADDRESS Eleanore R. Pfeiffer---Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS (hepatic met.) 1629 (known) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF LUNG (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION 142.4 NOT AGO | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CA OF LUNG | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE [Signature] DEGREE | | | | 22c. DATE SIGNED 21 Jun 81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. M. S. Williams, M.D. | | 22e. ADDRESS FGA FOUNTAIN, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/23/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Walter Brooks Bradley Inc. Balto., Md. 21222 | | | 25a. DATE REC'D. BY REGISTRAR JUN 23 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] |



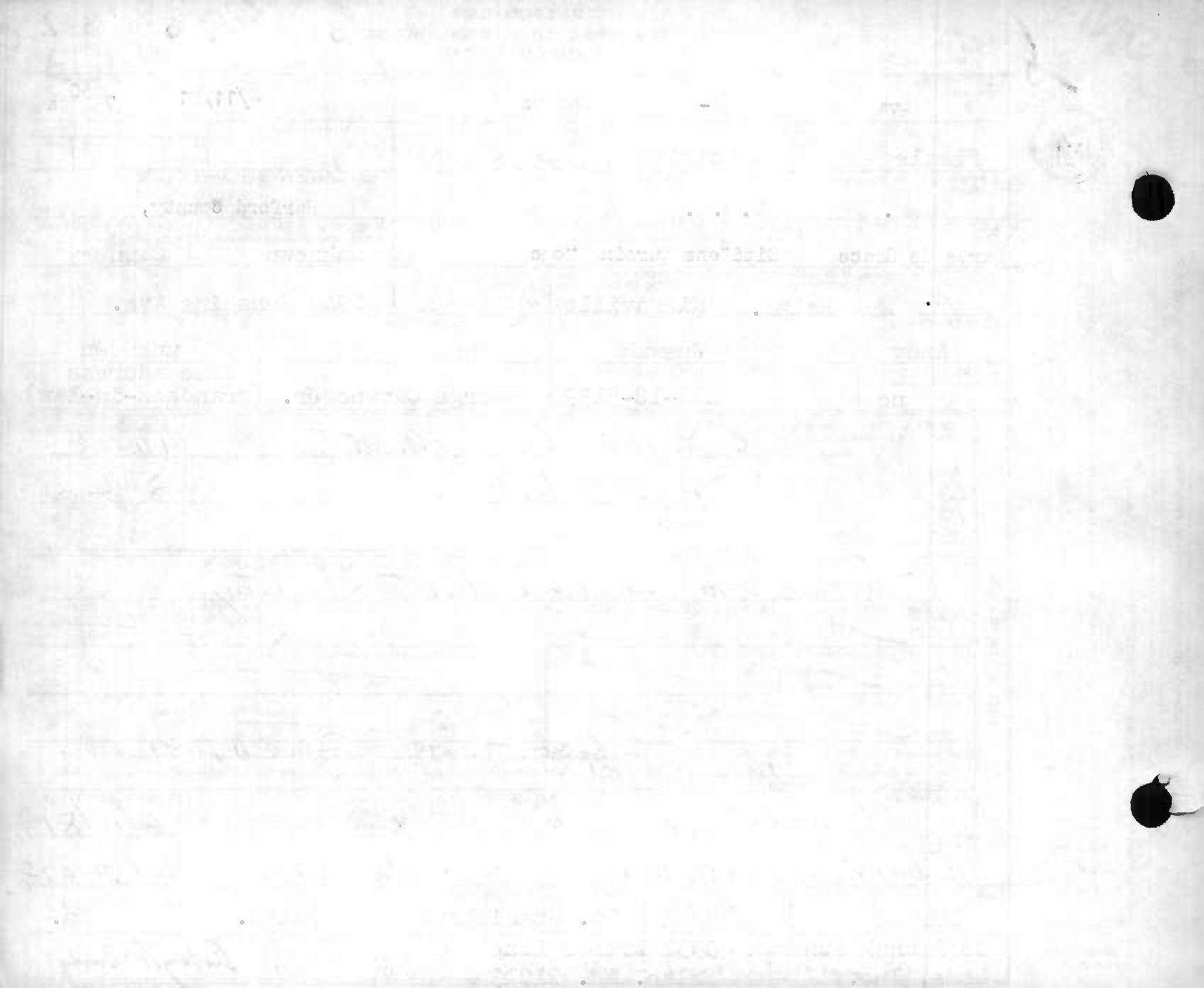
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 335-0302.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 1 6 1 3 2 | | | |
|---|--|---|--|---|--|--------------------------------------|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| Eva Phebus | | | | 6/11/81 | | | | 7 50 a.m. | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 IF UNDER 1 YEAR | | 8 IF UNDER 24 HRS | |
| Female | | Caucasian | | April 6 1888 | | 93 YRS | | MONTHS | | DAYS | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 9b. CITIZEN OF WHAT COUNTRY? | | 9c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md. | | U.S.A. | | | | Harford County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Harve de Grace | | Citizens Nursing Home | | unknown | | Cannery | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. INSIDE CITY LIMITS? | | | | 13c. STREET ADDRESS | | | |
| Md. Balto. Kingsville | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 6945 Sunshine Ave. | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First MIDDLE LAST | | | | First MIDDLE LAST | | | | | | | |
| Andy Juswak | | | | Anna unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | |
| no | | | | 218-18-5139 | | | | same address | | | |
| George Cavano Jr. (grandson-in-law) | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> | | | |
| 4292 (b) <u>A.S.C.V.D.</u> | | | | | | | | 3 years | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Brain Syndrome due to Senility</u> | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Brain Syndrome due to Senility</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 7, 1979</u> to <u>June 11, 1981</u> , that (I) (we) lost | | | | 22b. SIGNATURE <u>Edward C. Loo, M.D.</u> | | | | 22c. DATE SIGNED <u>6/11/81</u> | | | |
| saw the deceased alive on <u>June 11, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EDWARD C. LOO, M.D.</u> | | | | 22e. ADDRESS <u>Harve de Grace, Md. 21078</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. STATE | |
| Burial | | | | 6/13/81 | | St. Stanislaus | | Balto. | | Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Schumnek Funeral Home, Inc. | | | | 3331 Brehms Lane Balto. Md. 21213 | | | | JUN 12 1981 <u>Patricia McBrady</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 1 6 1 3 3 | |
|--|--|---|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| Melvin George Quick Sr. | | | | | June 25 1981 | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| male | | | Caucasian | | 05 21 05 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MARYLAND | | | USA. | | 76 YRS. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Fallston | | | Fallston General Hospital | | Hartford MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13a. STREET ADDRESS | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | |
| Maryland | | | Hartford | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 17. INFORMANT (Soc) 879-8007 ADDRESS | |
| Edward Quick | | | Anna Courthaus | | 2706 Sandy Hook Road Forest Hill, Maryland 21050 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (Soc) 879-8007 ADDRESS | |
| UNKNOWN | | | 214-34-3244 | | Mrs. Stephen E. Quick | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | 14 HOURS |
| IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK | | | | | | |
| 4100 | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| (b) MYOCARDIAL INFARCTION | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| (c) ATHEROSCLEROTIC HEART DISEASE | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| | | P.M. 19 | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION (STREET) CITY OR TOWN COUNTY STATE | | |
| | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/25/81 to 6/25/81, that (I) (we) lost saw the deceased alive on 6/25/81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | |
| A.J. Sweetman | | M.D. | | 6/25/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | |
| SWEATMAN A.J. | | Fallston General Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | | June 27, 1981 | | Mountain Christos Ch. Cem. | | Fallston, Hartford Co., Maryland 21085 |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Joseph William Foster | | W. Broadway & Williams St. Bel Air, Maryland 21014 | | JUN 30 1981 | | |

Handwritten notes at the top of the page, including the date "20 12 20" and some illegible text.

Handwritten notes in the middle section of the page, continuing the text from the top.

Handwritten notes in the lower middle section of the page, featuring some diagrams or sketches.

Handwritten notes at the bottom of the page, including a signature and some concluding remarks.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 1 3 4

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) JOHN ROSCOE REEVES | | | 2a. DATE OF DEATH MONTH DAY YEAR 6-3-81 19 81 | | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR March 12, 1919 | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | 7b. HOUR 10:00 M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | | |
| 10. CITY OR TOWN OF DEATH HAVER DE GRACE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Road Construction |
| 13a. STATE Md | | | 13b. COUNTY HARFORD | 13c. CITY OR TOWN DARLINGTON | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Evert Reeves | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Crouse | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 218-07-8641 | 17. INFORMANT ADDRESS Mrs. Vena Reeves, Darlington Md. 21034 | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4599

IMMEDIATE CAUSE (a)

Cardiac failure 2°

DUE TO, OR AS A CONSEQUENCE OF

myocardial infarction or

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

Pulmonary embolism

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Extensive Cancer of the colon, pancreas, duodenum & gallbladder

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-21 , 19 81 , to 6-3 , 19 81 , that (I) (we) last saw the deceased alive on 6-3 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Uberto R. Conary Jr | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 6/3/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) V.R. CARAG JR | 22e. ADDRESS HMH | | |

| | | | |
|---|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 6-6-81 | 23c. NAME OF CEMETERY OR CREMATORY Dublin Southern | 23d. LOCATION CITY OR TOWN COUNTY STATE Dublin, Harford Co., Md. |
| 24. FUNERAL DIRECTOR NAME ADDRESS John H. Harkins 600 Main St., Delta, Pa. | | 25a. DATE REC'D. BY REGISTRAR JUN 9 1981 | |
| | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

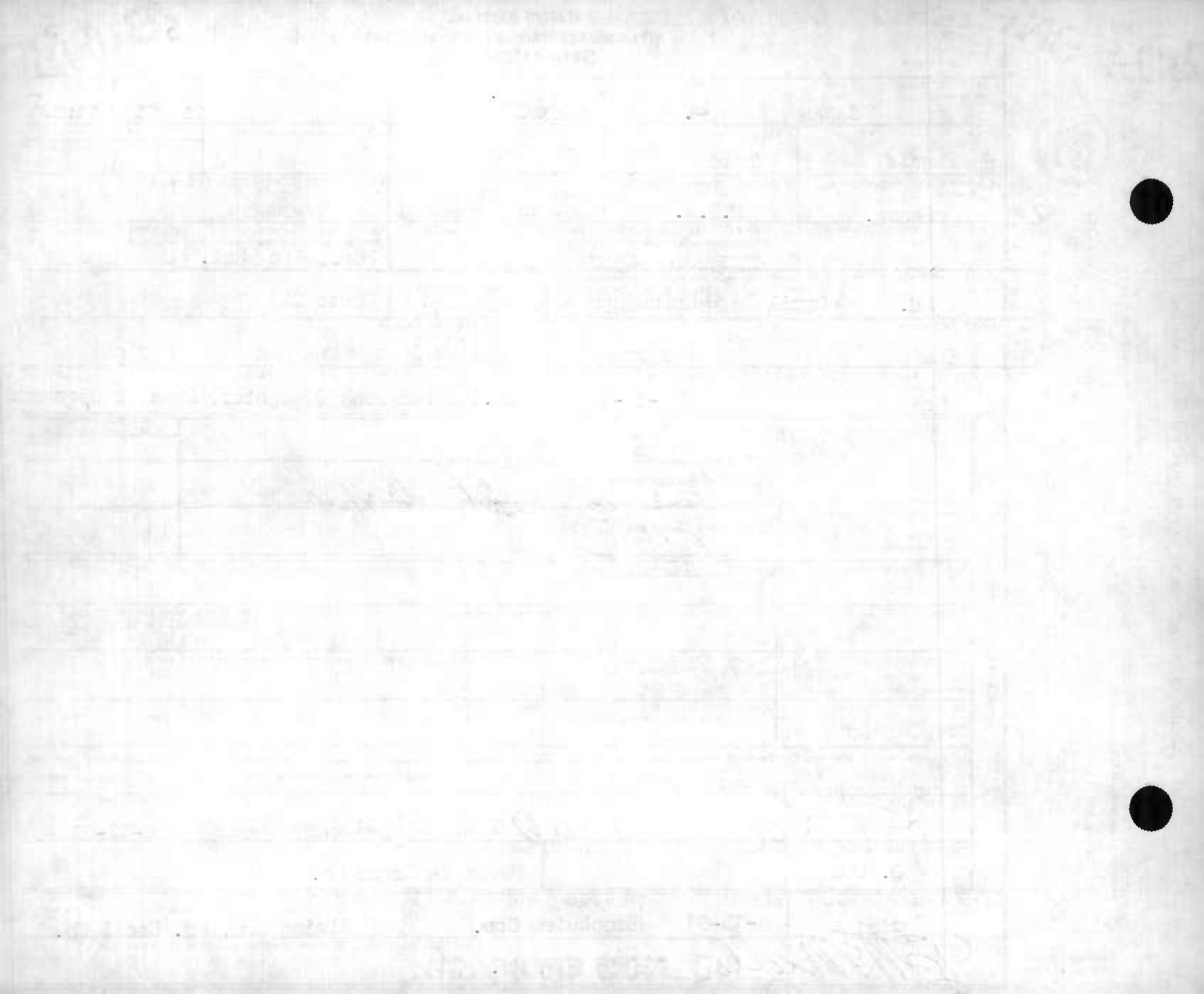
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Item 3 and 4 G 556 6/23/81 GB | | | | STATE OF MARYLAND | | 8 1 6 1 3 5 | |
|---|--|--|--|--|--|---|---|
| 1 - STATE REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | |
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) SARAH Lavenia REYNOLDS | | | | 7a. DATE OF DEATH MONTH DAY YEAR 6 11 81 | | 7b. HOUR 11:20 ^P _M | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 26 1888 | | 6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD | |
| 10 CITY OR TOWN OF DEATH HAVRE DE GRACE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife Ret. | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE Md. | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Conowingo | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Edwin Perice | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Seliva Jane Unk Unk Perice | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-22-1610A | | 17 INFORMANT ADDRESS Mrs. Eva Holbrook (Daughter) Same as Deceased | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Fr of left hip DUE TO, OR AS A CONSEQUENCE OF (c) C.B.S. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE J. Loo | | | | DEGREE UP | | 22c. DATE SIGNED 6-12-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Loo | | | | 22e. ADDRESS Havre De Grace Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6-15-81 | | 23c. NAME OF CEMETERY OR CREMATORY Brookview Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rising Sun, Md. Cecil Co. | |
| 24. FUNERAL DIRECTOR Name J. M. Muller | | | | ADDRESS Rising Sun, Md. | | 25a. DATE REC'D. BY REGISTRAR JUN 16 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Rising Sun, Md. | | | |

BP _____

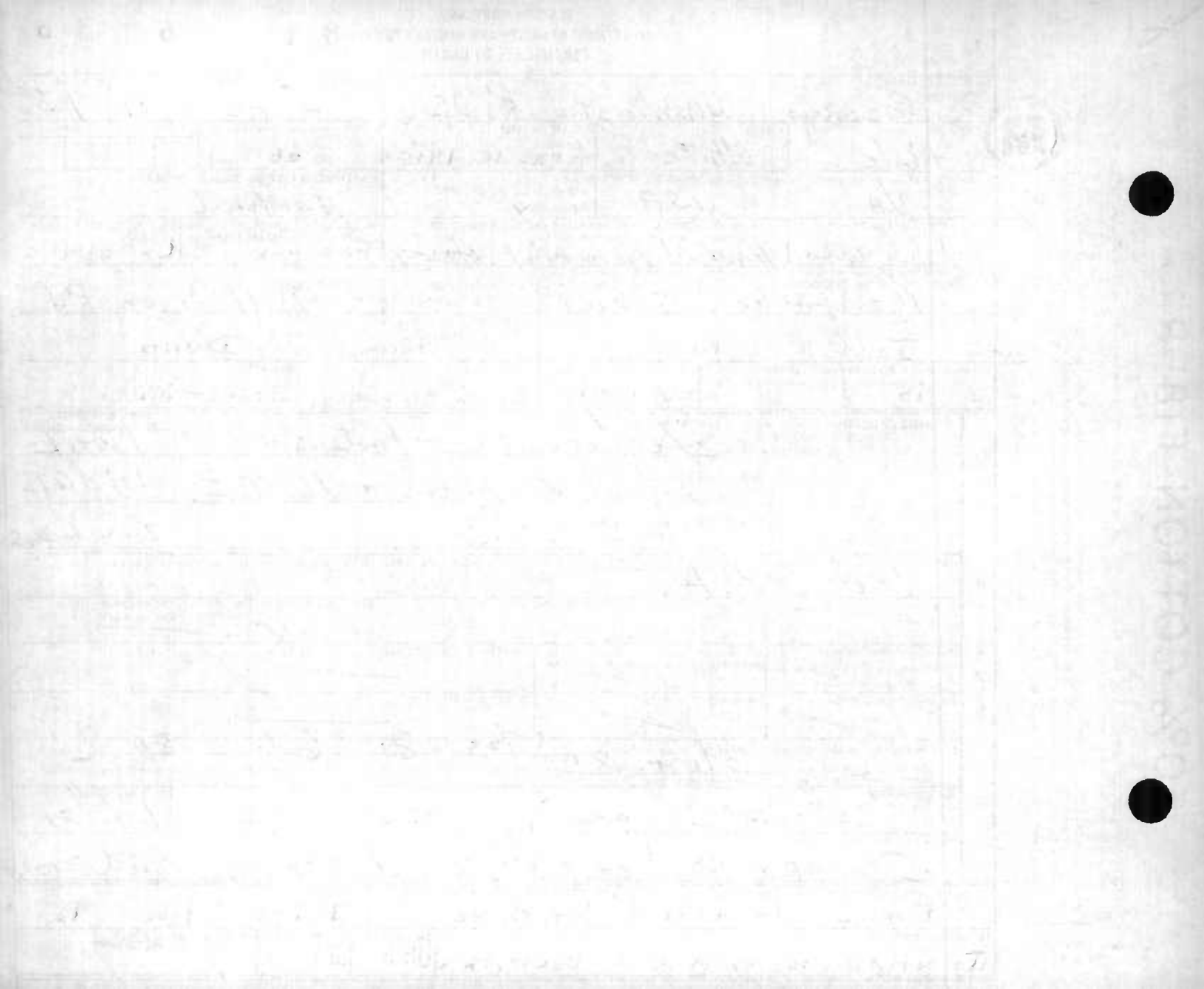


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 6 3 6 | | | |
|---|--|--|--|---|--|---|---|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George Washington Rippey | | | | 2a. DATE OF DEATH MONTH DAY YEAR June 1 81 | | 2b. HOUR 1 P.M. | |
| SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR APR. 16, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 66 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD. | |
| 10. CITY OR TOWN OF DEATH HARFORD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSP | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOREMAN | | 12b. KIND OF BUSINESS OR INDUSTRY LUMBER | |
| 13a. STATE Md. | | | | 13b. CITY OR TOWN HARFORD | | 13c. STREET ADDRESS Mill Green Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN RIFFEY | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NANNIE DUNN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. 225-18-9136 | | 17. INFORMANT ADDRESS EDITH BILLINGS, STREET, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line fatal, (b) or (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia - proteus 4292 Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause lost. (b) Decubitus ulcer & U. T. I. (c) A. S. C. U. D. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 10 days 3-4 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Old C.V.A. | | | | | | | |
| 19a. DATE OF OPERATION 5/23 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Septicemia | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, ADD IN MEDICAL EXAMINER) NOT WHILE AT WORK | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Septicemia | | | |
| 21d. INJURY OCCURRED NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) Home | | 21f. LOCATION (STREET) CITY OR TOWN COUNTY STATE Harford Md. Harford Md. | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/1/81 to 6/1/81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Edward C. Loo | | | | DEGREE MD | | 22c. DATE SIGNED 6/1/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. LOO | | | | 22e. ADDRESS Harford Md. 21078 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 6-4-81 | | 23c. NAME OF CEMETERY OR CREMATORY MT. NEBO | | 23d. LOCATION (CITY OR TOWN) COUNTY STATE DELTA YORK PA. | |
| 24. FUNERAL DIRECTOR NAME JOHN H. HARKINS | | | | ADDRESS 600 MAIN ST., DELTA, PA. | | 25a. DATE REC'D. BY REGISTRAR JUN 5 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 1 3 7

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas Robert Rink | | | 2a. DATE OF DEATH MONTH DAY YEAR June 15 1981 | | 2b. HOUR MIN. 5 25 | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 7 27 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | | |
| 10. CITY OR TOWN OF DEATH Havre de Grace | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (Ret) Driver | | 12b. KIND OF BUSINESS OR INDUSTRY City Govt. | |
| 13a. STATE MD | | | 13b. COUNTY Harford | 13c. CITY OR TOWN Havre de Grace | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FOREST F Rink | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Miller | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 711 07 4741 | | 17. INFORMANT ADDRESS (Wife) Mary Rink Same as #13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) of Lung 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ASCUS & COPD | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. certify that (I) (this hospital) attended the deceased from 5-30 19 81 , to 6-15 19 81 , that (I) (we) lost saw the deceased alive on 6-15 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Dante Monakile | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 6/15/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL | | 22e. ADDRESS 672 S Union Ave Havre de Grace MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 18JUNE81 | | 23c. NAME OF CEMETERY OR CREMATORY Angel Hill Cemetery | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Havre de Grace, Ha., MD | | 25a. DATE REC'D. BY REGISTRAR JUN 18 1981 | | | | |
| 24. FUNERAL DIRECTOR NAME Mitchell Funeral Home, Havre de Grace, MD | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1810-1811 Annual Report of the
General Land Office, Department of the Interior
Washington, D.C.

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8 1 1 6 1 3 8

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | |
|--|---------|---|---|---|---|--|---|--|--------------------------------------|---|---------|
| 1. DECEASED-NAME (Type or Print) | | | First | Middle | Last | 2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year | | | | 2b. HOUR | |
| Georgia Rebecca Risher | | | | | | 19 81 /m M | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD Month Day Year | | 2d. HOUR | |
| Female | Black | March 24, 1916 | 65 YRS. | | | | | 19 81 /m M | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | Md | |
| Va. | | USA | | | | Harford | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Aberdeen | | | 111 D Hanover Street | | | Return | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Harford | | Aberdeen | | | | 111 D Hanover Street | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Jacob | | | | | Woodley | Cora | | | | | Jackson |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| NO | | | 220-03-5223 | | | Family - | | | James on about. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>a Brain tumor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>ASCVD.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Luis E. Renjel</u> M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) Luis E. Renjel, Havre de Grace, | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) Harford County MD | | | June 3, 1981 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | June 5, 1981 | | Baltimore National Cem. | | Baltimore Baltimore MD | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Tarring Funeral Home PA, 333 S. Parke Aberdeen | | | | | | JUN 5 1981 | | | | | |

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Black Canyon, 1911

Black Canyon

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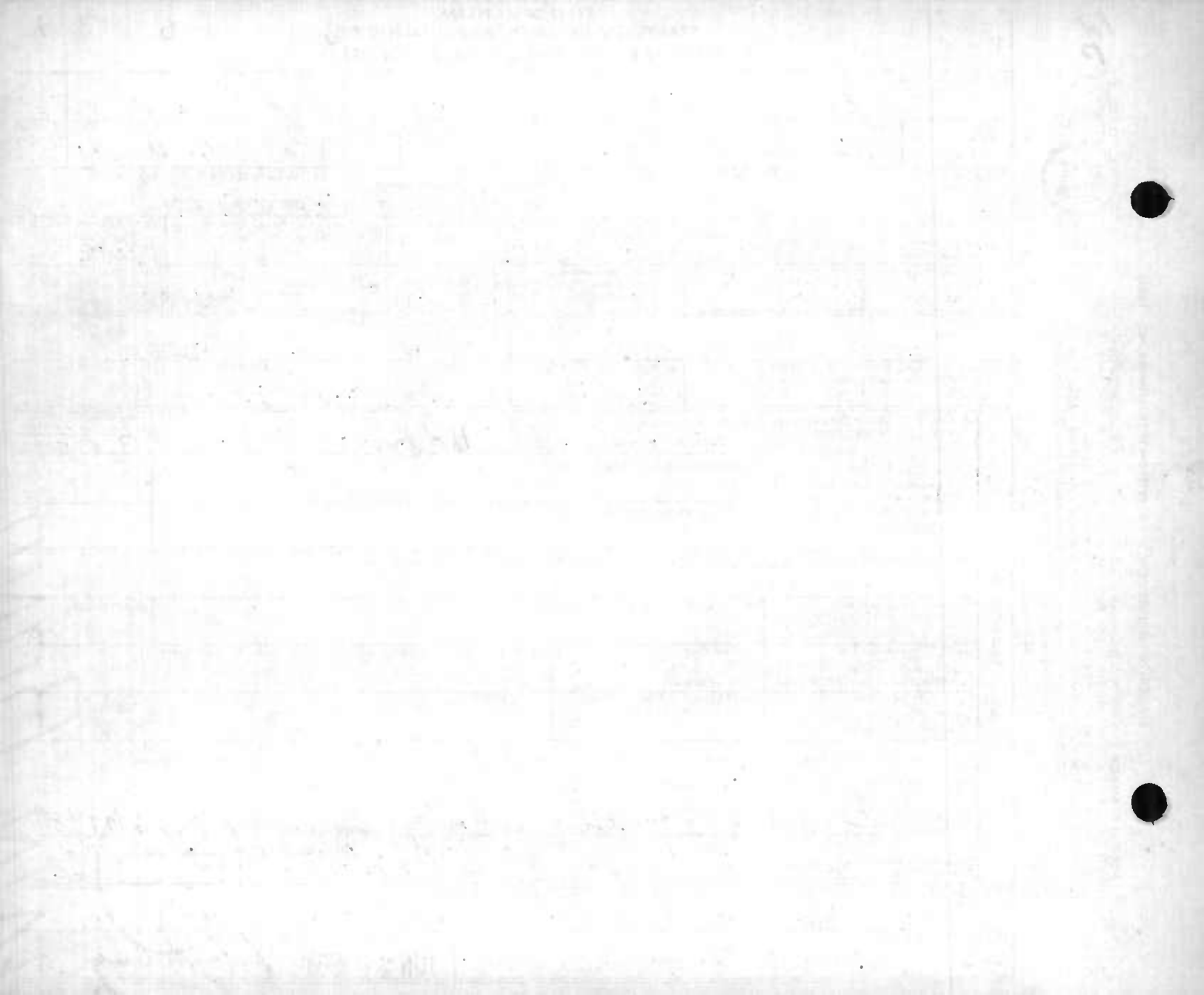
about 111

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMMH - 17
(VR A15 ME (5))
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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 16139 | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Bertie Bell Schaub | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6-21 1981 | |
| 3. SEX Fe 4. RACE Wh 5. DATE OF BIRTH MONTH DAY YEAR APRIL 24, 1909 6. AGE (IN YEARS) LAST BIRTHDAY 72 YRS. 7. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 2b. HOUR 4:57 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 2c. DATE PRONOUNCED DEAD 6-21 1981 2d. HOUR 4:57 P.M. | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH FALLSTON 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SHOE | |
| 13a. STATE MARYLAND 13b. COUNTY HARFORD 13c. CITY OR TOWN ABINGDON 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET ADDRESS 3010 LAUREL BUSH ROAD | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GEORGE A. CULLUM 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE -- THOMPSON | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 218-26-0277 17. INFORMANT ADDRESS CLARENCE M. SCHAUB, ABINGDON, MD. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulated Abdominal hernia 5522 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION _____ 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____ | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____ P.M. 19 _____ | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) _____ | |
| 21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____ | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Samuel H. Henck M.D. Deputy MEDICAL EXAMINER DATE SIGNED 6/21/81 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Samuel H. Henck ADDRESS 7210 Wheeler School Rd. White Ford, Md. 21160 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE JUNE 24, 1981 23c. NAME OF CEMETERY OR CREMATORY COKEBURY U.M. CEMETERY 23d. LOCATION CITY OR TOWN ABINGDON COUNTY HARFORD STATE MD. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME HOWARD K. McCOMAS III, ABINGDON, MD. ADDRESS _____ | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 23 1981 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 1 4 0

REG. NO.

| | | | | | | | | | |
|--|---------|---|--------|--|---|--|--|-----------------------------|----------|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| LUCIA ANNA | | | | Scheffler | 6 | 30 | 81 | | 7 AM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| F | C. | JAN. 10, 1936 | | | 45 | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| W. GERMANY | | GERMANY | | | | | HARFORD MD | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Fallston | | Fallston Gen Hosp. | | | HOUSEWIFE | | -- | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | | | |
| MARYLAND | | HARFORD | | EDGEWOOD | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | 16. STREET ADDRESS | | | | |
| FRANZISKUS ALOYSIUS SCHEFFKA | | ANNA MARIA MINNA KLINGEBIEL | | | 603 SORRELWOOD COURT | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | |
| NO | | 056-56-2435 | | | OTTMAR A. SCHEFFLER, EDGEWOOD, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE METASTASES 1729 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF MALIGNANT MELANOMA. (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 6/30, 1981, to 6/30, 1981, that (we) lost saw the deceased alive on 6/30, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE M. A. THOMAS M.D. | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 6/30/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. A. THOMAS | | | | 22e. ADDRESS FALLSTON GEN. HOSPITAL MD21047 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| BURIAL | | JULY 6, 1981 | | ARLINGTON NATIONAL CEMETERY, ARLINGTON-VA. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| HOWARD K. MCCOMAS III, ABINGDON, Md. | | | | JUL 2 - 1981 | | | | | |

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

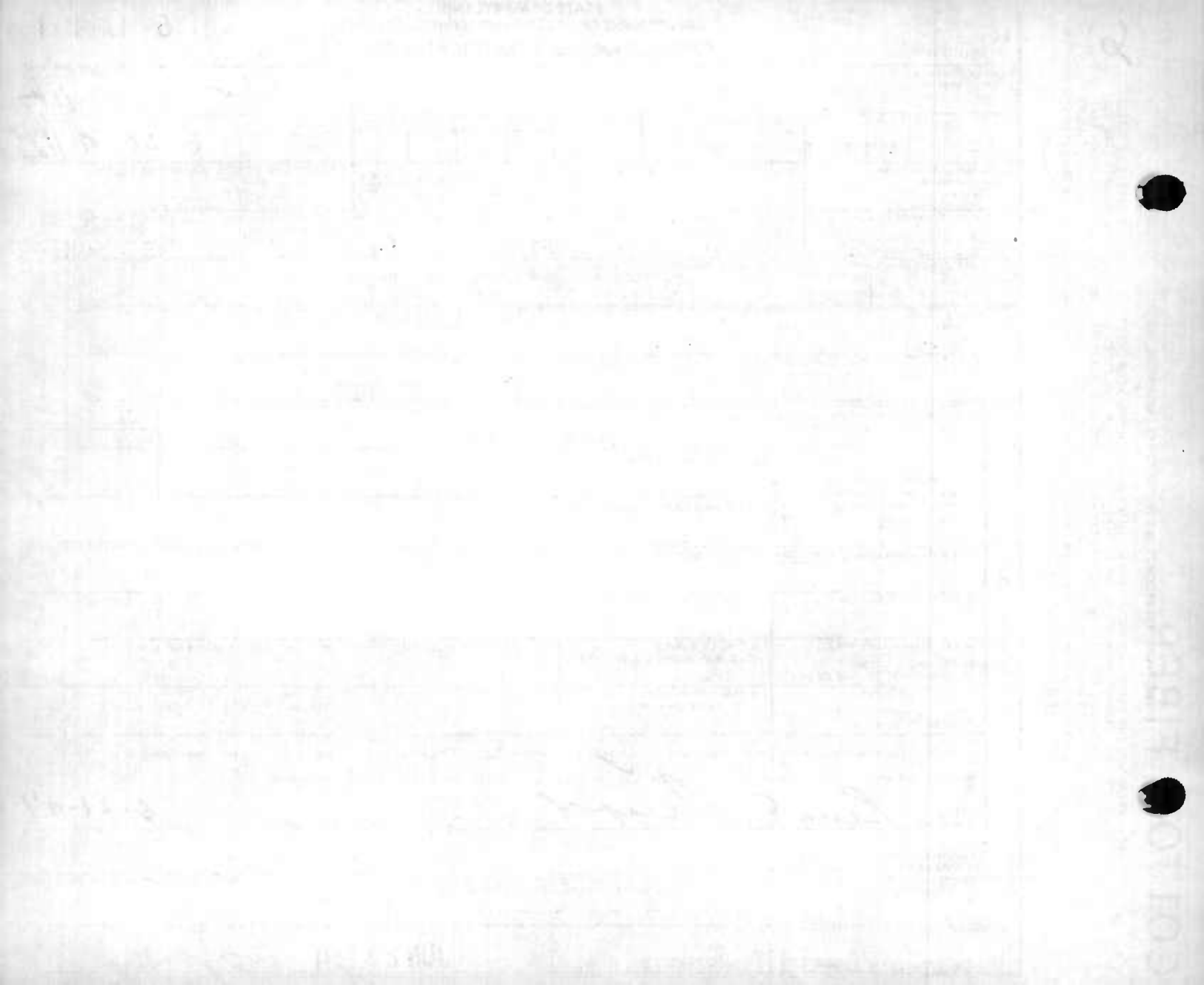
DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|--|---------|---|--|---|--|---|--|---|--|---|--|---------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | <input type="checkbox"/> MONTH DAY YEAR | | 2b. HOUR M | |
| RONALD EUGENE SEAL | | | | | | | | <input checked="" type="checkbox"/> JUNE 20, 81 | | | | 11:00 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR M | |
| MALE | WHITE | AUG. 18, 1954 | | 26 YRS. | | | | | | 6 20 81 | | 11:00 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| MARYLAND | | USA | | | | HARFORD COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| HAVRE DE GRACE | | HARFORD MEMORIAL HOSPITAL | | SHORT ORDER COOK | | RESTAURANT | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | |
| MARYLAND | | HARFORD | | ABERDEEN | | | | 801 CHELSEA ROAD | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| ARNOLD LEE SEAL | | MARY JANE JACKSON | | YES | | US Army Res. 212-60-3507 | | ROLAND LEE SMITH, ABERDEEN, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 9108 | | Drawing? | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (c) stating the under- lying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| | | (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) M.D. DEPUTY | | MEDICAL EXAMINER | | DATE SIGNED | | 6-21-81 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | LUIS E. RENJEL, M.D. | | ADDRESS | | 464 ALLIANCE ST. HAVRE DE GRACE, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| BURIAL | | JUNE 23, 1981 | | MT. ZION CEMETERY | | BEL AIR HARFORD MD. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| HOWARD K. McCOMAS III, ABERDONGON, MD. | | | | JUN 23 1981 | | [Signature] | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 1 6 1 4 2 REG. NO. | | | |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie D. Sheehy | | | | 2a. DATE OF DEATH MONTH DAY YEAR June 15, 1981 | | | | 2b. HOUR 10:15 P.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Mar 20 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | 7. IE UNDER 1 YEAR MONTHS DAYS | | 7. IE UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Hampshire | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Harre de Grace | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Aberdeen | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Duraut | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Valliere | | | | 13e. STREET ADDRESS 305 Irish Lane | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 001-05-6780 | | 17. INFORMANT ADDRESS Mrs. Royce Palmer, Aberdeen, MD 21001 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Urinary Tract Infection, Retracting 5990 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Delete, Meliars; Parkinsonism; ABCVD | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6-15-81 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-15-81 to 6-15-81 , that (I) (we) lost 6-15-81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. | | | | | | | | | | | |
| 22b. SIGNATURE Robert P. Robinson, M.D. | | | | DEGREE M.D. | | | | 22c. DATE SIGNED 6-16-81 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Jun. 18, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Harford Mem. GARDEN ABERDEEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE Harford MD | | | |
| 24. FUNERAL DIRECTOR NAME TARRING FUNERAL HOME, P.A. | | | | 24b. ADDRESS 323 S. PARKE STREET | | 25a. DATE REC'D. BY REGISTRAR JUN 19 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |



Handwritten notes and stamps, including a date stamp "JUL 1952" and various illegible markings.

Extensive handwritten notes and stamps, including a date stamp "JUL 1952" and various illegible markings.

Items #18a-22a Film G557 7/13/81
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|---|--|---|--|--------------------------------------|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| ANTHONY | | Lee | | SICE | | | | 6 | | 19 | | 81 | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Male | White | July 25, 1961 | | 19 | | YRS. | | | | 6 | | 19 | | 81 | | 5:30A | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Maryland | | USA | | WIDOWED | | DIVORCED | | Harford County | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Havre de Grace | | Harford Memorial Hospital | | Laborer | | Henkel/McCoy | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | Cecil | | Port Deposit | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 216 Jackson Park Road | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Martin | | Sice | | Betty | | K. | | Sisk | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| Yes | | 1979-80 | | 214-76-7322 | | Martin B. Sice, Port Deposit, Maryland | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1 DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| 9820 | | IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| | | (c) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | 6/19/81 | | inhaled exhaust fumes | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | |
| | | garage | | 216 Jackson Park Rd. Port Deposit Cecil Co. MD | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| death resulted from: | | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | |
| Hormez R. Guard, M.D. | | M.D. Assistant | | 6/19/81 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| Hormez R. Guard, M.D. | | 111 Penn Street, Baltimore, MD 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPEC) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | |
| Burial | | June 22, 1981 | | Mt Erin Cemetery | | Harford, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | DATE RECEIVED | | REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Lee P. Patten | | Baltimore, Maryland | | 6/19/81 | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
 (VR A15 ME (5))
 15M2/80

July 25, 1961

U.S.A.

Marine

X

Carl

Marine

Port Deposit

X

B.

Martin

Line

Betty

L.

Jim

1977-80

Y en

314-78-3322

Martin & J. Lee, Port Deposit, Maryland

Wish

June 25, 1961 at Port Deposit

See also: Port Deposit, Maryland

1977-80

314-78-3322

1977-80

1977-80

1977-80

1977-80

1977-80

1977-80

1977-80

1977-80

1977-80

1977-80

1977-80

1977-80

1977-80

1977-80

1977-80

1977-80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 1 1 6 1 4 4 | | | |
|--|--|--|--|--|---|---|------------------------------------|---------------------|----------|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | | | | |
| PAUL NMN Simmers | | | | | 6-13-81 | | | | M | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| M | | W | | March 26, 1898 | | 83 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | U.S.A. | | | | HARFORD MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| HARFORD | | HARFORD MEMORIAL HOSPITAL | | | | | | | | Electrician | | Engineering | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| MD. | | CECIL | | PERRYVILLE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 620 CHARLES ST. | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Joseph D. Simmers | | | | | Rhoda Tyson | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | |
| No | | | | | Unknown | | Nolie C. Simmers | | | | | | |
| | | | | | 620 Charles Street | | | | | Perryville, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> | | | | | | | | | | | | | |
| 4110 } DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute coronary dissection</i> | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic cardiovascular disease</i> | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| <i>Chronic bronchitis</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| | | | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (in this hospital) attended the deceased from 4-30, 1978, to 6-13, 1981, that (I) (we) lost saw the deceased alive on 6-13, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and I did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | | | 22c. DATE SIGNED | | | |
| <i>[Signature]</i> | | | | | | | | | | 6/13/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | | | | |
| H. AMAKOWA M.D. | | | | | 315 So. Union Ave Hgt Md. 21078 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | | June 17, 1981 | | Hopewell Cemetery | | | Port Deposit Cecil Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | 25a. DATE REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| L. Patterson | | | | | JUN 19 1981 | | | | | <i>[Signature]</i> | | | |



U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

For the purpose of
the present investigation
the following material
has been selected

1914-15 1-1-15

1/15

1914-15 1-1-15

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

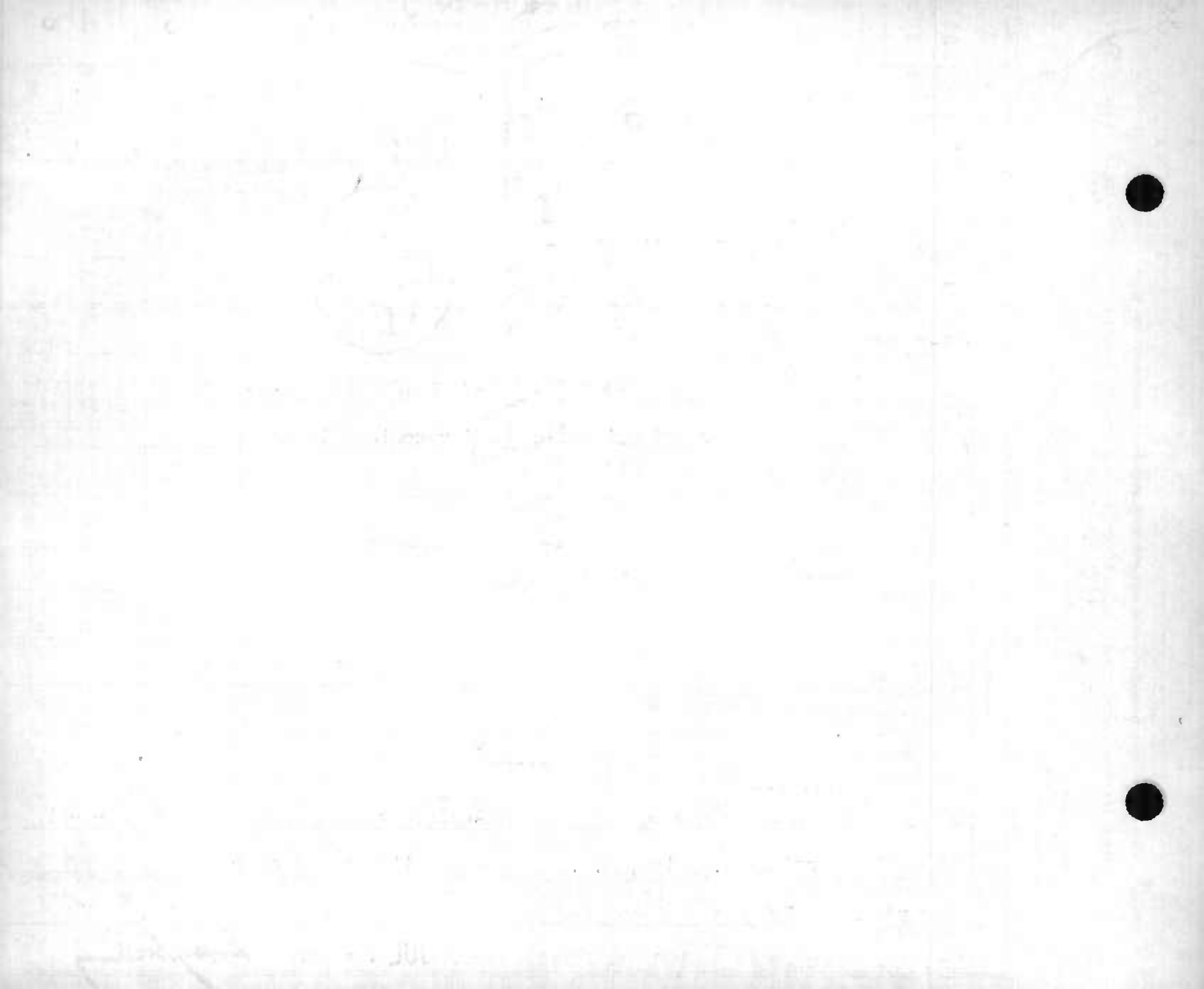
BP _____
DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 16145 | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Dorothy Johnson Snively | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH DAY YEAR <input checked="" type="checkbox"/> 6 23 1981 | |
| 3. SEX F 4. RACE W 5. DATE OF BIRTH MONTH DAY YEAR 9 3 15 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va. 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 2b. HOUR 7p M | |
| 10. CITY OR TOWN OF DEATH Aberdeen 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 170 West DeAn St. Aberdeen, MD 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 24 1981 7d. HOUR 7a M | |
| 13a. STATE MD 13b. COUNTY Harford 13c. CITY OR TOWN Aberdeen 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 170 West DeAn St. | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lester Johnson 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 220-36-6913 17. INFORMANT ADDRESS Dr. Kim's Office | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 2500 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) ASCVD (c) Diabetes Mellitus | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Luis E. Renjel M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 6-24-81 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D. ADDRESS 464 Alliance St. Havre De Grace, MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE June 26 1981 23c. NAME OF CEMETERY OR CREMATORY Baker's Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen Harford Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Tarring Funeral Home, PA ADDRESS 333 S. Parke Street Aberdeen, MD 21001 25a. DATE BY REGISTRAR JUN 26 1981 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 16146 | |
|---|------------------|---|---|---|--------------------------------|---|--|---|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thurman E. Stanley | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6 30 19 81 | | 2b. HOUR 2:40 P.M. | | | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 2 22 01 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 80 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD 7 1 19 81 | | 7d. HOUR P.M. | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Joppa | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 308 Old Philadelphia Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | 13b. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS P.O. Box 308 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Clarence Stanley | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 220-18-6984 | | 17. INFORMANT ADDRESS Emily Stanley P.O. Box 308 Joppa | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Carcinoma of stomach with metastases | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | | TITLE (SPECIFY) M.D. Assistant | | MEDICAL EXAMINER | | DATE SIGNED 7-2-81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/6/81 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR JUL 7 - 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death is not reported to the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death. If the death is not reported to the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed by the funeral director. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|--|--|--|---|-------------------------------------|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | | 8 1 1 6 1 4 7 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | |
| NEVA STEBBING | | | | | 6 11 81 2 55 AM | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | |
| Female | | W | | 6 11 19 | | 62 | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Virginia | | U.S. | | | | HARFORD County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Fallston | | Fallston General Hospital | | | | Housewife | | Home | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | | | | Harford | | Edgewood | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Otho Vannie Gray | | | | | Sarah E. Johnson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | | | | 213-12-8320 | | Lucile E. McDowell Joppa, Md. 21085 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Metastatic Disease | | | | | | | | | | |
| 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Car Cell Carcinoma of Lung | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) This post Cranberry + CHF. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | | CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-2-1981 to 6-11-1981, that (I) (we) lost saw the deceased alive above, (I) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | | |
| MURLI N. MATHEW, MD | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | |
| MURLI N. MATHEW, MD | | | | | 305 Fallston Fallston Md. 21041 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | | |
| Burial | | June 13, '81 | | Moreland Mem. Park | | Baltimore Co., Md. | | JUN 12 1981 | | |
| 24. FUNERAL DIRECTOR NAME | | | | | 25a. REGISTRAR'S SIGNATURE | | | | | |
| William E. Johnson 8521 Loch Raven Blvd | | | | | Ricky McReddy | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 1 4 8

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) JOSEPH Benjamin THOMAS | | | 2a. DATE OF DEATH MONTH DAY YEAR June 6, 1981 | | 2b. HOUR 7³⁰ PM |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 12/24/1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD. | |
| 10. CITY OR TOWN OF DEATH Fallston, Md. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | 12b. KIND OF BUSINESS OR INDUSTRY Farming | |
| 13a. STATE Maryland | 13b. COUNTY Harford | 13c. CITY OR TOWN White Hall | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 3262 Dry Branch Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Benjamin Thomas | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Julia Winder | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-32-2545 | | 17. INFORMANT ADDRESS Molly E. Thomas same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulm. Arrest 4349 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Infarcts, bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension, CHF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5/2/81 onset | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Pneumonia, probably asymptomatic | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 20, 1981 to June 6, 1981 , that (I) (we) last saw the deceased alive on June 6, 1981 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Albert S.C. Sun, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 6/7/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert S.C. Sun, M.D. | | 22e. ADDRESS 1800 Harford Rd. Fallston | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 6/10/1981 | 23c. NAME OF CEMETERY OR CREMATORY Union Chapel Cem. | | 23d. LOCATION CITY OR TOWN Monkton COUNTY Baltimore STATE Md. | |
| 24. FUNERAL DIRECTOR NAME M. Gladden Kurtz ADDRESS Jarrettsville, Md. | | 25a. DATE REC'D. BY REGISTRAR JUN 10 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

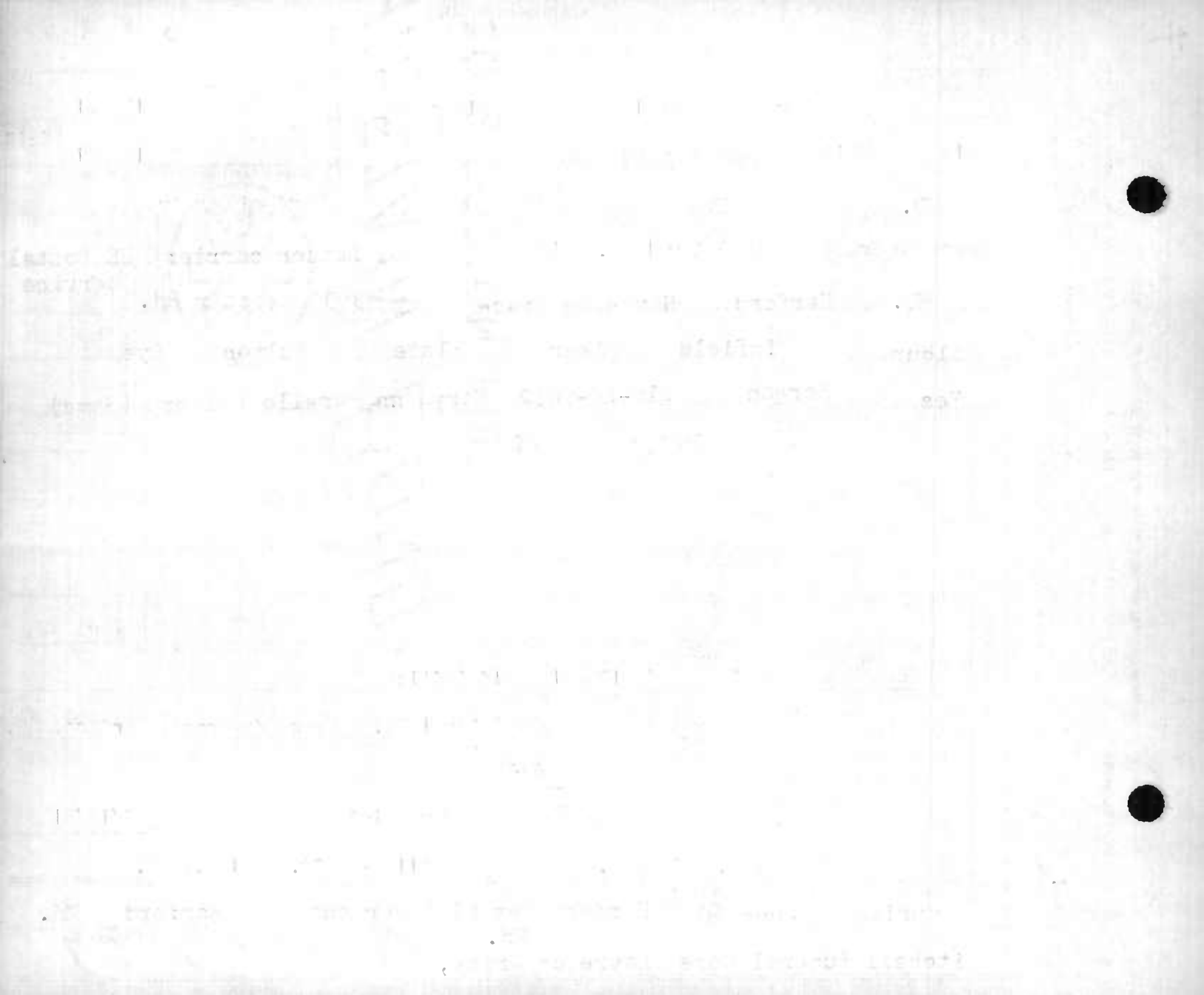
BP

DHMH-17
(VR A15 ME (5))
15M/2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---------|---|-------------------|--|---------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Robert Stanley Walker | | 6 17 1981 | | 6:15 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. |
| Male | White | March 8 1931 | 50 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| MD. | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Havre de Grace | | 3927 Level Rd. - in woods | | Letter carrier | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MD. | | Harford | | Havre de Grace | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | |
| Wilbur Winfield Walker | | Elsie Fulton Bye | | 216-28-9652 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Yes | | Korean | | Mary Ann Parello Walker (Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Shotgun wound of head | | | | | |
| 9551 | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | |
| (b) _____ | | | | | |
| (c) _____ | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | ? P.M. 6 17 1981 | | self inflicted | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | woods | | 3927 Level Rd. Havre de Grace, Harford, MD. | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Thomas D. Smith, M.D. | | Deputy Chief | | 6/18/81 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Thomas D. Smith, M.D. | | 111 Penn St. Balto., MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | June 20 1981 | | Harford Memorial Gardens | |
| 24. FUNERAL DIRECTOR | | 25a. DATE OF BURIAL | | 25b. SIGNATURE | |
| Mitchell Funeral Home | | June 22 1981 | | | |
| 26. NAME | | 26b. ADDRESS | | | |
| Havre de Grace | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 1 6 1 5 0

REG. NO.

| | | | | | |
|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Edith Webster Walls | | | 2a. DATE OF DEATH MONTH DAY YEAR June 2 81 | | 2b. HOUR 2:26 M |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 11 27 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD. | |
| 10. CITY OR TOWN OF DEATH HAVRE DE GRACE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSP | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | 13b. COUNTY HARFORD | 13c. CITY OR TOWN HAVRE DE GRACE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 911 Elizabeth St | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Francis Webster | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 220-14-0373 | | 17. INFORMANT Hortense James ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardio-vascular arrest 4029 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Ascorbic acid deficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 2 , 19 81 , to June 2 , 19 81 , that (I) (we) last saw the deceased alive on June 2 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, why did not view the body after death.) | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) AT. CALON | | 22e. ADDRESS 611 S. UNION Ave. Harford | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPEC) BURIAL | | 23b. DATE 6-9-81 | | 23c. NAME OF CEMETERY OR CREMATORY ST. JAMES | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Havre de Grace Harford Md. | | 23e. DATE REC'D. BY REGISTRAR JUN 8 1981 | | | |
| 24. FUNERAL DIRECTOR NAME Arnold W. Beard ADDRESS 117 Cecil Ave East Md | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

Handwritten signature

1981 8 JUL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 1 6 1 5 1 | | | |
|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR <i>AN</i> | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR HOUR | | | |
| ANNIE M. WATKINS | | | | 6 8 81 9 ⁰⁵ PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | Black | | MONTH DAY YEAR | | 53 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Rehoboth, VA. | | U.S.A. | | | | HARFORD County MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| FALLSTON | | FALLSTON GENERAL HOSP. | | Housewife | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | |
| Md. | | | | Baltimore | | 116 Chestnut St. | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | |
| David Rux | | | | Jennie McCornish | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | | Robert P. Watkins 116 Chestnut | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Ventricular Tachycardia</u> | | | | | | | |
| 2767 DUE TO, OR AS A CONSEQUENCE OF <u>Hypertension</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <u>Myocardial infarction, ischemic</u> | | | | | | | |
| (c) <u>Myocardial infarction, ischemic</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d) | | | | | | | |
| | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>6/8</u> 19 <u>81</u> , to <u>6/8</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>6/8</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| <u>Andrew Nowakowski MD</u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | <u>6/8/81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| ANDREW NOWAKOWSKI MD | | | | 715 Shamrock Road, Bel Air, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 6-13-81 | | Calvary Bapt Cem | | Rehoboth VA. | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| JAS. A. MORTON & SONS 1701 LAURENS | | | | JUN 10 1981 | | <u>John H. H. H.</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 1 1 6 1 5 2 | |
|---|--|--|--|--|--------------------------|--|--|---|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | |
| Datto B. Williams | | | | | June 12, 1981 | | | | | 1:10 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 7. IF UNDER 24 HRS. | |
| Male | | Negro | | April 5, 1892 | | 89 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md. | | U.S.A. | | | | Harford MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Havre de Grace | | Harford Memorial Hospital | | | | LABORER | | | P.R.R. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | |
| 13a. STATE 13b. COUNTY | | | | | 13c. CITY OR TOWN | | 13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| Maryland Harford | | | | | Havre de Grace | | 2501 Old Proctor Road | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| Solomon Williams | | | | | Vergie Brown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| no | | | | | | | Blaise Williams, Havre de Grace, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) ARTERIOSCLEROSIS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| Pneumonia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | 22c. DATE SIGNED | | |
| Dante Monakil | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 6/13/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| DANTE MONAKIL | | | | | | 622 S. Union Ave Harford, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | | | June 16, 1981 | | Union United Meth Cen | | CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | Harford Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Thelie J. Bullock, Havre de Grace, Md. | | | | | | JUN 18 1981 | | | | | |

